21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

17318

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17317

| | PLACE OF DEATH | | | | ution: Residence before odmi | ssion)/ |
|-----------------------|--|--|--|--|--|--------------------------|
| | a. COUNTY | MARYLAND | o. STATE | b. COL | JNTY | V |
| - | CITY OP TOWN Waystide corporate limit | C. LENGTH OF STAY IN 1b | CITY OD TOWN (15 | | IDAL I : | |
| | b. CITY OR TOWN (1) outside corporate limit, write RURAL and give nearest town) | 1 | 116. 1 1 1 | | URAL ond give neorest town |) |
| | Delhesda | DOA | I augus | y Jon | 71 W 4 | 7.3 |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in hi | ospitol, give street oddress) | d. STREET ADDRESS | / | e. IS RI | SIDENCE |
| | Suburhan | | 19 in 44 | 7 | | FARM? |
| ~ | | | xx // Vas | VKles/ | YES [| NO |
| | NAME OF First | Middle | Lost 4. | DATE Mor | 0 | Year |
| | (Type or print) / Obers | Saus 1 | eal | DEATH LLC, | | 961 |
| S. | SEX 6. COLOR OR RACE 7. M | ARRIED NEVER MARRIED | B. DATE OF BIRTH | 9. AGE (In years | | DER 24 HRS |
| | m white will | DOWED DIVORCED | Det. 9-19 | lost birthdoy) | Months Doys Hou | s Min. |
| 10o | USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR | 11. BJR HPLACE (County & St | | 12. CITIZEN OF WHAT | |
| | ng coest of working life, even if retired) | ANDUSTRY. | 100 | , | COUNTRY? | |
| 1 | accept | 710. 17 LAR | Alena | w | 11.21 | |
| 18. | FATHER'S MAME | | 14. MOTHER'S MAIDEN NAM | E | | |
| | John Kass | 2 Neal | thoras 1 | lember | · y | |
| 15. | WAS DECEASED EVER IN U.S. ARMED ORCES? | 16. SOCIAL SECURITY NO. 17. | INFORMANT | Add | ess | 1 |
| (A & | stho, or unknown) (If yes give war or dotes of servi | (e) 351-03-3121 7h | arion R | 1 | some as | |
| _ | war Many | | arion a | ex | aline | |
| | 1B. CAUSE OF DEATH (Enter only one coup per PART I. DEATH WAS CAUSED BY: | line for (o), (b), ond (c).) | | | INTERVAL | |
| | IMMEDIATE CAUSE (o) | cute Cerenary thr | omb es is | | ONSET AN | |
| | 4201 DUE TO | | | | | -0-00 |
| | Conditions if any which save | Advanced severe o | ananana antan | | | |
| | rise to immediate couse (a) | THE VICEGOR SOVETO C | elemany arrea | Tescretesia | year | 3 |
| | stoting the underlying couse DUE TO | | | | | |
| | | | | | | |
| | lost. (c) | | | | | |
| , | | BUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDIT | ON GIVEN IN PART 1(o) | 19. WAS A | UTOPSY |
| NOIL | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE | BUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDIT | ON GIVEN IN PART 1(o) | 19. WAS A PERFO | |
| FICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE | | | | 19. WAS A PERFO | UTOPSY RMED? NO |
| RTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE | BUTING TO DEATH BUT NOT RELATED TO 20b. DESCRIBE HOW INJURY OCCURRED. | | | | |
| L CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE | | | | | |
| MCAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED 20e. PLA | (Enter noture of injury in Port | | | |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED 20e. PLA: While Not While foct | | I or Port II of item 1B.) | YES 🛨 | NO C |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While foct | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) | I or Port II of item 1B.) 20f. (City or town) | (County) | NO (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour 'o.m. p.m. 19 21. I certify that (I) (this haspital) | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) | I or Port II of item 1B.) 20f. (City or town) | (County) | (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) | I or Port II of item 1B.) 20f. (City or town) | (County) | (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour 'o.m. p.m. 19 21. I certify that (I) (this haspital) | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) | 20f. (City or town) M, fram causes | (County) | (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 death accurred at the strength of the strength o | 20f. (City or town) And the second of the s | (County) (County) (I) (I) (I) (I) (I) (I) (I) (| (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 220. SIGNATURE | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 193 t death accurred at the control of the contro | 20f. (City or town) M, fram causes | (County) (County) And an the date state | (Stote) |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 22c. PHYSICIAN'S | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 death accurred at the strength of the strength o | 20f. (City or town) And the second of the s | (County) (County) (I) (I) (I) (I) (I) (I) (I) (| (Stote) (we) la |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 22c. PHYSICIAN'S NAME (Type) HENGER | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work attended the deceased fram and that M.E. | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 | 20f. (City or town) M, fram causes STAFF PHYS. | (County) 19 that (I) and an the date state 22b. DATE SIGNED 9 DEC | (Stote) |
| 230 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, BURIAL, CREMATION, BURNAL, CREMATION, BURNAL, CR | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work of work attended the deceased fram | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 | 20f. (City or town) And the second of the s | (County) 19 that (I) and an the date state 22b. DATE SIGNED 9 DEC | (Stote) (we) la |
| MEDICAL CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, BURIAL, CREMATION, BURNAL, CREMATION, BURNAL, CR | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work of work attended the deceased fram 19 , and that M.E. 23c. NAME OF CEMETERY OR | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) It death accurred available of the phys. ATTENDING MEDING DIR 22d. ADDRESS | 20f. (City or town) M, fram causes CTOR PHYS. 23d. LOCATION (City or Town) | (County) (County) And an the date state 22b. DATE SIGNED 22b. DA | (Stote) (we) la ed abav |
| 2300 CC 24 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, REMOVAL (Specify) TEMBER 20 12/12/67 FUNERAL DIRECTOR | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 death accurred at the death accurred a | I or Port II of item 1B.) 20f. (City or town) M, fram causes STAFF ECTOR PHYS. 23d. LOCATION (City or To | (County) (County) (County) And an the date state 22b. DATE SIGNED 22b. DATE SIGNED 20wn) (County) Maryland | (Stote) (we) la |
| 2300 CC 24 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this haspital) saw the deceased alive an 220. SIGNATURE 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, REMOVAL (Specify) 12/12/67 | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work | (Enter noture of injury in Port CE OF INJURY (Home, form, ory, street, office bldg., etc.) 1 death accurred at the death accurred a | I or Port II of item 1B.) 20f. (City or town) M, fram causes STAFF ECTOR PHYS. 23d. LOCATION (City or To | (County) (County) And an the date state 22b. DATE SIGNED 22b. DA | (Stote) (we) loc ed abay |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban capers. Preshall be filed with the State Dept. af Health priar to burial, crematian, ar remaval, and in any event, within 724 had Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67

TO A PAIN THE STREET WITH THE PARTY OF THE WITH THE POUNT OF THE PARTY mencipance wy - DC I disking Ton I we EL3() Lebertage 427 Complered Today free here - the. I 70 W To La - - - - Och 9- 1810 57 Theyer In HIAM Selvin 200 Get Town the thing ways We to the Many the In Mercent have and the same af somitional tracks, were taken wherey has much. The state of the s Minimum of the state of the sta munitize of , colotte rate to apply the sure of the sure of the state o

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CEDT | IFIC | ATF | OF | DE | ATH |
|------|------|-----|----|----|-----|
| | | | | | |

17318

| | | | | | | | | 710 | 1 | |
|---------------------------|---|-----------------------------|-----------------------------|------------------|--|------------------|---------------------------------|--------------------------------|-------------------------------|----------------------|
| PLACE OF DE O. COUNTY | | | | | 2. USUAL RESIDENCE (V | | h COUN | | efare admissi | an) |
| | Montgomery | | MARY | - | | yland | | MOS | | |
| b. CITY OR TO | OWN (If outside corparate limits | , | c. LENGTH OF STAY II | N 1b | c. CITY OR TOWN (If ou | tside carp | arate limits, write RUF | RAL and give ne | arest tawn) | |
| | AL and give nearest town) | | 45days | | Kens | ingto | on | | 15 | / |
| d. NAME OF I | OSPITAL OR INSTITUTION (If no | t in hospital, g | ive street address) | | d. STREET ADDRESS | | | | e. IS RESI | |
| Naval | Hospital | | | | 4216 Antl | | | | YES | NO 😿 |
| 3. NAME OF DECEASED | Fir | | Middle | BYEIT M | Last | 4. DAT | | | Day Ye | |
| (Type or prin | | | Y. | - | HOUSE | DEA | | | 21 19 | 67 |
| S. SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | | . DATE OF BIRTH | | 9. AGE (In years last birthdoy) | Manths Da | | Min. |
| Male | Cauc | WIDOWED | DIVORCED | | Nov. 30, 19 | | 46 yrs. | | | |
| 10a. USUAL OCCUI | PATION (Give kind af wark dane orking life, even if retired) | | ND OF BUSINESS OR DUSTRY | | 11. BIRTHPLACE (County | & State, at | r foreign cauntry) | 12. CITIZEI | N OF WHAT | |
| U. S | . Navy | | DOSTAT | | Romney, | West | Virginia | | USA | |
| 13. FATHER'S NA | AME | | | | 14. MOTHER'S MAIDEN | | | | | |
| Robert | Newhouse | | | | Zona Shan | k | | | | |
| 15. WAS DECEAS | ED EVER IN U.S. ARMED FORCES? | | SOCIAL SECURITY NO. | 17. 1 | NFORMANT Street | | Addge | ënsingt | on Ma | 2 |
| Yes, na, ar unkn | awn) (If yes give war or dates a 1942-1962 | f service) | 2 26 0598 | Mary | s. Margaret | | Nouhouso | lioza A- | thomas | |
| | OF DEATH (Enter only one cau | | | I Ivit | s. Margaret | D. I | HEMITOUSE, | 4210 AL | INTERVAL BE | TWEEN |
| | I. DEATH WAS CAUSED BY: | | | the | urinary bla | rahha | 2 | | ONSET AND I | |
| 12 | / MMEDIATE CAUSE | (a) | CINOMA OI | one | ur mary bra | auuei | | | | |
| 101 | DUE | TO | | | | | | - 1 | | |
| | if onγ, which gove) nediate cause (a), | (b) | | | | | | | | |
| | underlying cause DUE | TO | | | | | | | | |
| last. | | (c) | | | | | | | | 7 |
| PART II. OT | HER SIGNIFICANT CONDITIONS CO | ONTRIBUTING T | O DEATH BUT NOT REL | ATED TO 1 | HE TERMINAL DISEASE COI | NDITION G | IVEN IN PART 1(a) | | 19. WAS AUT PERFORM YES | OPSY MED? NO 🗽 |
| OR CONTRIB | NT WAS UNDERLYING UTING CAUSE OF DEATH OTIFY MEDICAL EXAMINER) | 20b. DE | SCRIBE HOW INJURY O | CCURRED. | Enter nature of injury in | Part I or | Part II of item 18.) | | | 404.5 |
| ₹ 2Dc. TIME (| DF INJURY Month, Day, Year jur a.m. p.m. 19 | 20d. IN While at wash | Nat While at wark | | E OF INJURY (Hame, farmary, street, affice bldg., etc. | | f. (City ar tawn) | (Caunty |) | (State) |
| 21. I saw t | certify that XI) (this hose | pital) attend | ded the deceased | fram and that | Nov. 7 | 9_67 | , taDec2 M, fram causes | 1 , 19 <u>67</u> and on the | that (I)c(| we) las d abave |
| 22a. SIGNA | | 1 | / | | | | | 22b. DATE | | |
| | Murules | U. | Tome | ML | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | Dec. | 21,19 | 967 |
| 22c. PHYS | CIAN'S Lawrence | A. Jone | | | 22d. ADDRESS Naval He | ospit | al, Bethe | | | |
| 23o. BURIAL, CR | | | 23c. NAME OF CEME | FTERY OR | | | LOCATION (City or To | | | State) |
| REMODAL 1 | | | | | Cemetery | 1 | Romney, We | , | 17 | 2.410) |
| 24. FUNERAL D | RECTOR Tyson Whee | | nera lookome | | 2So. REC | | | GISTRAR'S SIGN | _ | LERA |
| | ckrille Pike | | | | | EC S | | Muare | A House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages than should be filed with the State Dept. at Health priar to burial, crematian, ar remaval, and in any event, within 72 hour ofter deat Page 4 may be retained by the hospital ar attending physician.

VR A15 (4) 25M 1/67

THE MARKET PROMINE TO LEGISLANCE AND THE PROMINE SERVING A PROMINE AND ADDRESS OF THE PARTY OF T #12:11 утвепри гео! (ferral abase and HELD Anthony Boness OF TOTAL 1802 W. B. Dayy Mary Street, Mounty, West Vicetoia __新楼里 斯拉尔 . DM . Hodgit rock! SEC 25, 0529 State Har gard H. Heathwell, 1920 Annang rebbaid wheniam out to amonicsel. 是有一个人,我们们的是一个人,但是一个人,但是一个人,我们就是一个人,我们就会一个人,我们就会一个人,我们就会一个人,我们就会一个人,我们就会一个人,我们就会 Billian V feel recent granters Describe toll I tolling the Describe

17319

| 1. | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) |
|---------------|--|--|
| | O. COUNTY TO THE | o. STATE D. COUNTY D. |
| | b. CITY OR TOWN (If outside corporate limits) c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give process town) |
| 1 | b. CITY OR TOWN (If outside corporate limits write RURAL and give hearest tawn) | C. CIT OK TOWN (II outside corporate limits, write kokat and give peutest town) |
| | Rethisday / days | Rumantour 191 |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| | A. Parla | Pt # 2 BO 49 YES TINO DO |
| | NAME OF First Middle | |
| 3. | The state of the s | Unlead OF Day |
| | (Type or print) WILTRED Donald IVIC | HOLSON DEATH Dec 26 1967 |
| S. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthdoy) Months Doys Hours Min. |
| 17 | make 11) hat WIDOWED DIVORCED | 2/15/18 49 yrs. 100111113 DOYS 110013 1111111. |
| 10 | o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & State, ar foreign country) 12. CITIZEN OF WHAT |
| | ring most of working life even if retired) INDUSTRY | COUNTRY? |
| 6 | Enemal Caretakee N 1 H | Comas ma 954 |
| 13 | 3. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | Glora & Mehalson | Mary C. Whish |
| 15 | | INFORMANT 10413 mosts Address Pare |
| (| (es, new runknown) (If yes give wor or dotes of service) 2 14 -30 -82 85 | re 112. 11. 10 But Dd. |
| | 10 | INTERVAL RETWEEN |
| 40 | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH |
| | IMMEDIATE CAUSE (0) | of the liver syear |
| 10 | 5810 DUE TO | 0 |
| | Conditions, if ony, which gove) (b) | |
| | rise to immediate cause (o), | |
| | stoting the underlying couse | |
| | lost. (c) | 10 WAS AUTODSY |
| Z | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? |
| 100 | Hypokalema | YES NO X |
| CERTIFICATION | 200. ACCIDENT WAS UNDERLYING \(\square\) 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or Port II of item 18.) |
| 197 | OR CONTRIBUTING CAUSE OF DEATH | |
| 4 | (IF EITHER, NOTIFY MEDICAL EXAMINER) | ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d. INJURY OCCURRED to foc | ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) |
| × | p.m. 19 of work of work | |
| | 21. I certify that (I) (this hospital) ottended the deceased from_ | Dec , 1957 to Pee 26, 1967, that (1) (we) la |
| | saw the deceased alive on Dec 26 19 67, and that | at death occurred of \$33\$ M, fram causes ond on the date stated abov |
| | 220. SIGNATURE | 22b. DATE SIGNED |
| | | D. ATTENDING MED. STAFF DIRECTOR DIRECTOR PHYS. DIPORT 1967 |
| | A VOCE V COLOR | 22d. ADDRESS |
| | 22c. PHYSICIAN'S/ NAME (Type) | ZZG. ADDRESS |
| | | |
| 2 | 30. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | CREMATORY 23d LOCATION (City or Town) (County) (Stote) |
| | REMODAL (Specify) 12/29/67 Monoca | cy Dealls ville Monta - Md |
| 3 | 24. FUNERAL DIRECTOR ADDRESS | 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE |
| 1 | 1 STORE OF THE STO | DOC JAN 2 1968 There Indae |
| 1 | Wellow, B. Hellow, Darneson | LO MEC DATE |

filled

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon should be filed with the State Dept. af Health priar to burial, crematian, ar remaval, and in any event, when VR A15 (415) 20 M 1/66 THE THEORY IN WHITE REPORTED AND RECEIVED AN THE THE PERSON OF TO A STATE OF THE STATE OF - - CONSTRUCTOR | 100 | - 1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | . 2 | | 17321 | | | CERTI | FICATE (| F DEATH | | | 17320 |) |
|--|--|-----------------|---|--|---|--------------------------------------|----------------|--|-----------------------------|--------------------------------------|----------------|---|
| er death funeral | and 2 er death. | 1. | PLACE OF DEATH o. COUNTY MONTGO | MERU | | MAI | RYLAND 2 | O. STATE | E (Where deceased | b. COUNT | | |
| by the | 高到 |) | b. CITY OR TOWN (If outs write RURAL and give | ide corporote limits, | | C. LENGTH OF STAY | | CITY OR TOWN (II | outside corporate | | | |
| iin 24 ho filled in | | | d. NAME OF HOSPITAL OR | INSTITUTION (If not | in hospitol, giv | ve street oddress) | d | STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES NO |
| d withi | 8 | 1L | NAME OF DECEASED (Type or print) | CHARL | | Middle | Non | Lost | 4. DATE OF DEATH | Month | 20 | 1967 |
| executed wit d campletely | n any event | n | PALE W | HITE | WIDOWED [| NEVER MARRI | | 15/08 | ALC: NO | AGE (In yeors lost birthdoy) 7 Yrs. | Months Doys | Hours Min. |
| ate be ex | | du | USUAL OCCUPATION (Give ing most of working life, ex DWINER | kind of work done ren if retired) | • IND | O OF BUSINESS OR USTRY LIMBIER | * FUEL | MARY | nty & Stote, or foreig | n country) | 12. CITIZEN OF | ? |
| certifica g physi | vermit. Then please an, ar remaval, and i | | FATHER'S NAME CHARL | | | eris | | . MOTHER'S MAJES | EN NAME | Bowma | trus . | |
| death | permit. Tian, ar rei | | WAS DECEASED EVER IN U es, no, or unknewn). (If yes | | · · · · · · · · | 7-09-16; | 17. INFO | | WIFE | Addres — Sx | AME | |
| that the death certificate be executed within 24 haurs after deat ian. by the attending physician and campletely filled in by the funeral | būrial-transit pe burial, crematia | | 18. CAUSE OF DEATH (PART I. DEATH WA 490/ | Enter only one couse S CAUSED BY: IMMEDIATE CAUSE (o DUE TO | Myoc | o), (b), ond (c).) cardial i | nfarcti | on | | | | TERVAL BETWEEN ISET AND DEATH |
| w requires ing physic sen signed | the burial- r to burial, | | Conditions, if ony, which rise to immediate coustoting the underlying last. | n gove) . (b | cord | onary art | erioscl | erosis v | with thro | mbosis | | |
| : The larant ar attend te has be | use as alth prio | ATION | PART II. OTHER SIGNIFIC | | · — — — — — — — — — — — — — — — — — — — | DEATH BUT NOT R | ELATED TO THE | TERMINAL DISEASE | CONDITION GIVEN | N PART 1(o) | | WAS AUTOPSY PERFORMED? |
| PHYSICIAN e haspital c his certificat | far f He | L CERTIFICATION | 20o. ACCIDENT WAS UNDE OR CONTRIBUTING □ CAI (IF EITHER, NOTIFY MEDIC | JSE OF DEATH | 20b. DESC | RIBE HOW INJURY | OCCURRED. (Ent | er noture of injury | in Port I or Port II | of item 18.) | | |
| VG PHY the he this e | e detached ate Dept. a | MEDICAL | 20c. TIME OF INJURY N Hour o.m. p.m. | lonth, Doy, Yeor 19 | 20d. INJ While of work | URY OCCURRED Not While at work | | F INJURY (Home, t street, office bldg., | | City or town) | (County) | (Stote) |
| rrendig nined by OR: Afte | hauld be th the Stat | | saw the decea | at (1) (thi) haspi | tal) oftende | | | at accurred | , 165 to at 456 A M, | fram kauses a | nd an the dat | |
| DIRECT | ge 3 sh | | 22c. PHYSICIAN'S | obers | 4/ | Macon | M,D. | ATTENDING PHYS. 22d. ADDRESS | MED. DIRECTOR | STAFF PHYS. | 22b. DAY SIGN | 67 |
| O HOSPITAL OR ATT Page 4 may be retain O FUNERAL DIRECTO | director, page shauld be filed | 230 | NAME (Type) BURIAL, CREMATION, | 23b. DATE THER | FOF | 23c. NAME OF CE | WELEDA UD CDET | 809 | Viers | TION (City or Tow | Kick (County | WIK, Ho |
| Page TO FUN | | 2 | REMOVAL (Specify) | 1 | 67 | Honoc | acy | | Bea EC'D BY REGISTRAR | elsulle | Monta. | mid |
| VR A1 25M 1 | 1/67 | 2 | William | c Wilte | -, Ba | meane | th. In | DATE | | 201 | 0 | July 3 |

TESTS OF THE PROPERTY OF THE P the state of the state of the

MARYLAND STATE DEPARTMENT OF HEALTH

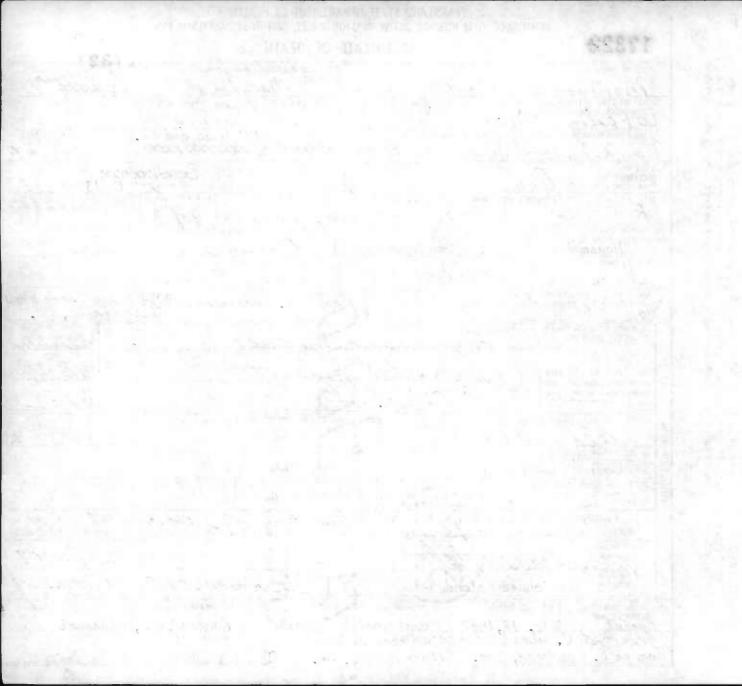
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| - | | 5 7 2 9 4 | | | | | | | | |
|---------------|--|--|--|--|--|--|--|--|--|--|
| | PLACE OF DEATH O. COUNTY | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE b. COUNTY | | | | | | | | |
| | Manlamery County MARYLAND | Maryland Courty | | | | | | | | |
| | b. CITY DR TDWN (If butside corporate mits, C. LENGTH DF STAY IN 16 / write/RURAL angleive nearest town | c. CITY DR TDWN (If conside corporate limits, write RURAL and give neares town) | | | | | | | | |
| | where 1/10 3-1-67 | Silver Opring 15:1 | | | | | | | | |
| | d. NAME OF HOSPITAL OR INSUTUTION (If not in hospital, give street address) | d. STREET ADDRESS) 121 Brad and Rd. e IS RESIDENCE | | | | | | | | |
| | Kandalph Hills Nursing Hime | GOXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | | | | | | | | |
| | NAME OF DECEASED (Type or print) On New Middle | well 4. DATE OF DEATH DEATH DEATH DOT DOT DOT DOT DOT DOT DOT D | | | | | | | | |
| S. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | | | | | |
| | P WIDOWED DIVORCED | uq. 10 1870 gr yrs. Months Doys Hours Min. | | | | | | | | |
| | . USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Own Home | M. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | |
| 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | | | | | |
| L | Isaac U. Beckett | Susan Milan | | | | | | | | |
| 15. (Ye | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17/8 17/9 17/9 17/9 18/9 19/9 19/9 19/9 19/9 19/9 19/9 19 | rooks E. Soderstrum 90% Sligo Creek Pkwy. Silver Spring. Md. | | | | | | | | |
| | 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) | INTERVAL BETWEEN | | | | | | | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Derepherel wester | Chycelless Institute | | | | | | | | |
| | DUE TO | | | | | | | | | |
| | Conditions, if ony, which gove) (b) has a condition of the conditions of the condit | infacet minutes | | | | | | | | |
| | rise to immediate couse (o), stating the underlying couse DUE TO | U- 11 | | | | | | | | |
| | lost. (c) Arlerios leros | is search | | | | | | | | |
| 2 | PART II. OTHER-SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY | | | | | | | | |
| CERTIFICATION | 818 als (97) | PERFORMED? YES NO | | | | | | | | |
| IIFIC | 20o. ACCIDENT WAS UNDERLYING \(\text{20b DESCRIBE HDW INJURY DCCURRED.} \) | (Enter noture of injury in Port I or Part II of item IB.) | | | | | | | | |
| | OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| MEDICAL | | CE OF INJURY (Home, form, 20f. (City or town) (County) (State) | | | | | | | | |
| MED | | ory, street, office bldg., etc.) | | | | | | | | |
| | 21. I certify that (I) (this haspital) attended the deceased from | march , 1967, to 12/13, 1967, that (1) (we) last | | | | | | | | |
| | sow the deceased alive on 12/15 19/17, and that | death accurred at/o:400M, fram couses and on the date stoted above. | | | | | | | | |
| | 220. SIGNATURE MERITARI PROCESSION M.E. | ATTENDING MED. STAFF 22b. DATE SIGNED 12/14/1967 | | | | | | | | |
| | 20. PHYSICIAN'S NAME (Type) Richard Delandy | 4323 HAVARDST. SILVERSPRING, Md. | | | | | | | | |
| 230 | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | CREMATORY , 23d. LOCATION (City or Town) (County) (Stote) | | | | | | | | |
| | Burial Dec. 18, 1967 Mount Moriah | Cemetery Kansas City, Missouri | | | | | | | | |
| 124 | JUMEA DIRECTOR C. Glen Carter 8434 ADDRESS rgia A | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| ti | arner E. Pumphrey Inc. Silver Spring | Md DARFC 1 & 1967 Minuta Present | | | | | | | | |

TO FUNERAL DIRECTOR: After this certificote hos been signed by the attending physician and completely filled li director, page 3 shauld be detached for use as the burial-transit permit. Then please remove corbon paper should be filed with the State Dept. of Health prior to burial, crematian, or removal, and in ony event, within 72 Poge 4 moy be retained by the hospital or attending physician. VR A15 (4) 25M 1/67

IO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofte<u>r d</u>eath.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

and 2

CERTIFICATE OF DEATH

| | | | | | | | | | 11 | 340 | | |
|---------------|----------------------------|--|---------------|-----------------------|-----------|--|------------------|--|--------------------|------------|-------------------|-----------------|
| | PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (W | Vhere deced | | | nce befor | e admissio | on) |
| | o. COUNTY | | | MARY | AND | o. STATE | 1 | b. CQU | INTY | Can | 00 - 0 | V |
| | b CITY OR TOWN (| outside corporate limits, | | c. LENGTH OF STAY II | | c. CITY OR TOWN PILE OUT | tside carpar | rate limits write RI | IPAL and air | | rges | |
| | write RURAL and | give pearest town) | | C. LENOTH OF STATE | . 10 | | | gic illinis, wille Ke | MAL UNU GI | ve medios | 1/ | 7 |
| | Takona | , tork | | 3 days | | | le | | | | 1600 | 1 |
| | d. NAME OF HOSPIT. | AL OR INSTITUTION (If not i | n haspital, g | give street address) | 1 | d. STREET ADDRESS | . 1 | | | | e. IS RESIL | DENCE ARM? |
| | Washingto | m Sanitaria | m é | - Hospita | id . | 7401 N | ew H | amp Shire | e Ave | ソ | - | NO 🗵 |
| | NAME OF DECEASED | First | | Middle | | Last | 4. DATE OF | Man | | Day | Yeo | or . |
| | (Type ar print) | | orge | Edwa | | Noyes | DEATH | | | | - 19. | |
| S. | SEX | 6. COLOR OR RACE | MARRIED | NEVER MARRIED | | B. DATE OF BIRTH | | AGE (In years last birthday) | IF UNDER Manths | Davs | IF UNDER Haurs | 24 HRS. Min. |
| | Male | White | WIDOWED | DIVORCED | | 8-7-9 | 3 | 74 yrs. | Mullilis | Duys | Lantz | Milit. |
| 10a | . USUAL OCCUPATION | (Give kind of work done | | ND OF BUSINESS OR | | 11. BIRTHPLACE (County 8 | & Stote, or fo | oreign cauntry) | 12. C | ITIZEN OF | WHAT | |
| dur | ing most of working | lite, even it retired) | | DUSTRY CORP | | 1 | | Md. | C | OUNTRY? | A | |
| 13. | FATHER'S NAME | | JTA. | OU CORP | , | 14. MOTHER'S MAIDEN N | IAME | | | 00 | | |
| | 01 | | | | | | 1 1 | 1 | | | | |
| 10 | | RINUS. ARMED FORCES | es | COCIAL CECUDITY NO | 1 17 1 | 1 Sabe | 1 V | rania | | | | |
| | | (If yes give war or dates of s | ervice) | SOCIAL SECURITY NO. | | | | Addi | ess | | | |
| 6 | anknown . | | _ 5 | 78-05-9877 | | Chart | | | | | | |
| | 18. CAUSE OF DE | ATH (Enter anly one cause | per line for | (9)2 (b), pnd (c).) | | C , / | | / | | | ERVAL BET | |
| | PART I. DEAT | TH WAS CAUSED BY: IMMEDIATE CAUSE (6) | 1/ | 4daus | - | Sto Kes | AHA | 90/65 | | Ph | SET AND C | DEATH Q |
| | 420 | DUE TO | V | 1 | _ | 0 - 0 | | | 1117 | 0 | **** | 3 |
| | Canditions, if ony, | | / | MIDCA | 111 | al inten | tion | | | 6 | 0.0 | 1 |
| | rise ta immediat | e cause (a), (| | 10,000 | un | 781760 | | A | | | · OPC- | |
| | stating the under | rlying cause (c) | | Anterio | 501 | enosis o | blit | enans | | 9 | ears | - |
| | PART II. OTHER SI | GNHF CANT CONDITIONS CON | TRIBUTING T | TO DEATH BUT NOT RELA | ATED TO T | THE TERMINAL DISEASE CON | DITION GIV | EN IN PART 1(a) | | 19. | WAS AUTO | OPSY |
| 10 | 1 | 1) iabeter | me | 2 Mitac | | | | | | VI | PERFORM | NO L |
| FICA | 20g. ACCIDENT WAS | | | | CURRED | (Enter nature of injury in F | Part Lar Pa | ert II of item 18 \ | | 1 / | | |
| CERTIFICATION | OR CONTRIBUTING | CAUSE OF DEATH | 200. 00 | SCRIBE HOW HOOK? OC | CORRED. | (Enter nature at injury in t | i dis i di i d | in it of hem 10. | | | | |
| | | MEDICAL EXAMINER) | 1 00 1 11 | T CONTRACTOR I | 00 01 44 | 11) Value 20 22 | 1 001 | 153 | 10 | | , | C |
| MEDICAL | Haur a.r | JRY Month, Day, Year n. | While | Nat While | | TE OF INJURY (Hame, farm, ary, street, office bldg., etc.) | | (City ar tawn) | (C) | ounty) | (| State) |
| × | p.r | n. 19 | at wark | | | - , , , , , , , , , , , , , , , , , , , | | , | | | | |
| | 21. I certif | y that (I) (this hospit | al) attend | ded the deceased | from/ | 2/13 ,1 | 967. | ta_/2/16 | , 19 | 67th | ot (1) (1 | we) la |
| | saw the de | eceased alive on 12 | 116 | 1967,0 | ind that | death accurred at | 11 de A | M, fram causes | and on | the dot | e stoted | abav |
| | 22a. SIGNATURE | 1 | | 0 | | | hen | 47.00 | 22b. 1 | DATE, SIGN | ED. | |
| | | Neuro | 11 | (Sug- | M.D | | MED. DIRECTOR | STAFF PHYS. | 1 18 | 2/16 | 167 | |
| | 22c. PHYSICIAN'S | 1 2000 | - | 7 | | 22d. ADDRESS | | | | | | |
| | NAME (Type) | | | V | | | | | | | | |
| 22- | BURIAL, CREMATIC | ON. 23b. DATE THERE | O.E. | 23c. NAME OF CEME | TEDV OD | CDEMATORY | 724 1 | OCATION (City or To | num! | (Caunty | 10 | tate) |
| 230 | REMOVAL (Specify Burial | | | | | | | . , | | , ,, | , | iuie) |
| - 04 | BUTLAL FUNERAL DIRECTO | | -01 | ADDRESS | comn | Cemetery | | ince Ge | | | - | |
| 24 | . FUNEKAE DIKECIO | | 7/ | | | DE C | BY REGIST | | EGISTRAR'S | | | |
| - | - A Man | #1/ mo 1 = 1/c | The Lawre of | a Washins | rton | D. C DATE | 1 41 | 100/1 | Chary | By V | udas | , |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the tyneral directar, page 3 should be detached far use as the burial-transit permit. Then please remave carban papers, Pages I and should be filed with the State Dept. of Health priar ta burial, crematian, ar removal, and in any event, within 72 hours after death Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

PESSEP (Asserting 226.

17324 FOR STATE HEALTH DEPT.

any delay is

2, and 3, to

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| d | w | 0 | 0 | 63 | |
|---|---|---|----|----|--|
| 1 | 6 | 0 | 16 | 3 | |

| 1. | PLACE OF DEATH | | | | 2. USUAL RESIDENC | E (Where deceased liv | | esidence before od | mission) |
|---------------|----------------------|---|------------------------|-------------------|--------------------------------|-------------------------|--------------------------------|--|-------------------------|
| | o. COUNTY | TGOMERY | , | MARYLAND | O. MARY | LAND | b. COUNTY | NTGOME | ERY |
| - | b. CITY OR TOWN (| If outside corporate limits. | c. LENG | TH OF STAY IN 1b | | outside corporote lim | | | |
| 1 | TAKOM | d give nearest tawn) | 14 | DAYS | SILVE | R SPRIN | ıc | 15 | 1 |
| - | d. NAME OF HOSPIT | AL OR INSTITUTION (If not in | | | d. STREET ADDRESS | -11 31 1011 | | | RESIDENCE |
| V | | ON SANITAR | 4 4 4 | | 1602 | CAREY | LANE | YES | N A FARM? |
| | NAME OF | | naction, | Middle | | 4. DATE | Month | | |
| 3. | DECEASED | A | CKU | 1.1 | CONNOR | OF | Month 2 | 2 E | Year 19 67 |
| - | (Type or print) SEX | AGNES | (N | MN) U | | DEATH | | NDER I YEAR IF I | JNDER 24 HRS. |
| 3. | F | 6. COLOR OR RACE 7 | MARRIED NI | DIVORCED DIVORCED | 8. DATE OF BIRTH | I look | (In yeors IFU birthday) Man | | ours Min. |
| | | (Give kind of work done | 10b. KIND OF BU | JSINESS OR | 11. BIRTHPLACE (St | ote or foreign country) | | 12. CITIZEN OF WH | IAT |
| dı | ring most of working | | Own don | | WASH | DC. | | COUNTRY | |
| 1: | 3. FATHER'S NAME | WIFE | I Own Mor | te | 14. MOTHER'S MAIDE | | - 1 | 00,7 | |
| | FRAN | K B M | LARTIN | | GRA | E Ma | CHESN | EY | |
| 11 | | R IN U.S. ARMED FORCES? | 16. SOCIAL SE | CURITY NO 1 | 7. INFORMANTIARTIS | | | | |
| | res, no, or unknown) | (If yes give wor or dotes of s | | -7/55 - | D_ large | n U Connor | Address 461 H St | - NU We | ish. D. (|
| _ | No | | 210-54 | - 1937 | TTS. CH | HART | | | |
| | 18. CAUSE OF DI | EATH (Enter only one couse TH WAS CAUSED BY: | per line for (o), (b), | and (c).) | 1 | 1 | | | AL BETWEEN AND DEATH |
| | 1/200 | IMMEDIATE CAUSE (o) | lard | iac 4 | rest | Lurin | 9 Du | rgery | |
| | 4000 | DUE TO | | . 4/ | 1 -41 | 2 4 | 4. | 00 | 1-1 |
| | Conditions, if ony | | assor | rated | with | urt | riock | lero | Rev |
| | rise to immediat | | 11 | 0.0 | 0. | | | | |
| | lost. |) (c) | Nea | ret a | tescas | 10.76 | Verklik | Horiza | 0 |
| | PART II. OTHER SI | GNIFICANT CONDITIONS CON | TRIBUTING TO DEATH | BUT NOT RELATED T | O THE TERMINAL DISEASE | CONDITION GIVEN IN | PART 1(a) | | SAUTOPSY |
| CERTIFICATION | | | | | | | | YES | FORMED? |
| FIC | 20o. EXTERNAL CA | AUSE WAS | 20b. DESCRIBE HO | OW INJURY OCCURRI | D. (Enter noture of injury | in Port I or Port II of | item 18.) | | |
| FRT | PRIMARY Or CO | NTRIBUTING | | | (*** | | , | | |
| CAL | 20c TIME OF INII | URY Month, Doy, Yeor | 20d. INJURY OC | TIPPED 20e | PLACE OF INJURY (Home, f | form. 20f. (City | or tawn) | (Caunty) | (Stote) |
| MEDICAL | Hour o.i | m. | While No | t While | foctory, street, office bldg., | | o. 151111, | (230.11) | (0.010) |
| | p.i | | | twork | | | _ | | |
| | 21. I certif | y that I took charge of | of the remains d | escribed abave, | held an Autopsy | , Inspection | , Inquiry | ond in | my opinion |
| | deoth result | ted from: Notural | causes A | cident S | uicide 🔲, 🛮 Homici | ide 🔲 , Undete | rmined monne | r 🔲 | |
| | ACTUAL | MANA | /// | // | CHIEF MEDI | CAL EXAMINER | | | |
| | SIGNATURE | VOLAGO | 111 | flat | In.D. | MEDICAL EXAMINER | | 22. | DATE SIGNED |
| | EXAMINER'S | 2 | 11 | 2 . 16. | DEPUTY ME | DIEAL EXAMPLER | Da | 2 71 | 1010 |
| | | CELDEN I | X. K | EAPI | 1. D. Address is | Ped aty bown or cou | inty) [160 | - · ×6,1 | 76/ |
| 23 | Bo. BURIAL, CREMATIC | | OF 23c. N | AME OF CEMETERY | OR CREMATORY | 23d. LOCATIO | N (City or Town) | (County) | (Stote) |
| | BEMOVAL (Specify | Dec. 27. | 1967 Re | ck Creek | | Washi | naton D | C | |
| | 4 FUNERAL DIRECTO | R LKI | nill | ADDRESS | | EC'D BY REGISTRAR | | AR'S SIGNATURE | |
| | Warner 5 | Promos or E | C. 8434 | Conscer | C C M DATE | DEC 29 19 | 167 rock | carles Ca | dag. |
| | VUILLE (| Countrioles In | C - X4 14 | Ga. Hiso | a) a) Marie | | MI A | The state of the s | The state of |

VR A15ME (5)

the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm PM3, Page

necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1,

TO DEPUTY MEDICAL EXAMINER:

This certificate shauld be executed within 24 haurs after death. If

5 may be retained far yaur files.

TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages land2 with the State Departmenta

Health prior to burial, cremation, ar remaval, and in any event within 72 haurs after death.

INTERNAL ASSESSMENT TO THE PROPERTY AND ADDRESS OF THE PARTY ASSESSMENT ASSES CONTRACTOR OF THE PROPERTY OF MONTGOINERY MARKENT MONTGOINERY TAMONA FARE STATE STATE STATE MASHINGTON STREET HOSPITAL 1602 CARSY LANG PACHES (MMM) D'CONNOR 12 25 67 30-8-1 X W 7 R FRANK B ITAKTIN CHACE MAGNESSIES No. 1653 11 16 the will see the continue to be a seemed March March Colored Co

FOR STATE

HEALTH DEPT. portment of

State Health prior to burial, gemation, or removal, and in any event within 72 hours after death.

This certificate should be executed within 24 hours ofter death. If the funeral director. Page 4 shauld be forwarded to the Chief Medical Examiner's Office along with form in pencil in Item 18. Give Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a buriol-transit permit. File pages lond2 with the pending necessory, please execute the certificate, writing the word TO DEPUTY MEDICAL EXAMINER: A 15ME (5)

17295

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| MEDICAL EXAMINER'S | CERTIFICATE OF DEATH 173 | 24 |
|---|--|--|
| 1. PLACE OF DEATH O. COUNTY MONT GOMETY MARYLAND | a. STATE Mary /and. b. COUNTY Mor | te before odmissian) 77 9 6 mer ef |
| b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) 3. C. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) | c. CITY OR TOWN (If autside carporate limits, write RURAL and give | |
| Suburban. | 5424 Mohican Ro | ON A FARM? YES NO X |
| 3. NAME OF DECEASED (Type or print) William - Nelson | Oliver OF DEATH Dec- | Day Year 9 1967 |
| | B. DATE OF BIRTH June 13,1900 9. AGE (In years lost birthday) Manths 7 yrs. | YEAR IE UNDER 24 HRS. Days Haurs Min. |
| 10a. USUAL OCCUPATION (Give kind af wark dane during mast af warking lite, even if relired) Insurance Agent 10b. KIND OE BUSINESS OR INDUSTRY Retired | Washington, D. C. (OI | IZEN OE WHAT UNTRY? U. S. |
| Joseph A. Oliver | Anna Kinsinger | |
| (Yes no ar unknown) (If yes give war ar dates of service) | nda P. Oliver Same as | Item 2. |
| rise to immediate couse (a), | Carbon Monexide Peisoning | INTERVAL BETWEEN ONSET AND DEATH minutes |
| stoting the underlying cause (c) Conflagration (Figure 1) | | 19. WAS AUTOPSY |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE Cerebral arteries eleres is | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) | PERFORMED? YES TO NO |
| 200. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING COLORED. CAUSE OF DEATH. HOUSE. CAUSE FLORE PRIMARY OF CONTRIBUTING COLORED. | (Enter noture of injury in Port I or Part II af item 1B.) | |
| | CE OE INJURY (Hame, farm, ary, street, affice bldg., etc.) Horme Left Schottigtte. | Montgonery Ma |
| 21. I certify that I taok charge of the remains described abave, he death resulted fram: Natural causes, Accident | ide an Autapsy , Inspection , Inquiry , ide , Hamicide , Undetermined manner , CHIEF MEDICAL EXAMINER , ASSISTANT MEDICAL EXAMINER , 12/9/6 DEPUTY MEDICAL EXAMINER Address (Street, city, tawn, ar county) Betheso | and in my apinian 22. DATE SIGNED A. Md. |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR REMOVAL CONSTITUTION 12-13-67 Cedar Hil. | CREMATORY 23d. LOCATION (City or Town) 1 Crematory Suitland Pr, | (Caunty) (State) Geo Md |
| Robert A Pumphrey 7557 Wisconsin | Ave DEC 15 1967 PEGISTRAR DATE DEC 15 1967 | GNATUR Judge |

Julian Charles II (1) Andrew ethiology (1) Andrew (2) Andrew (2) Andrew (3) A The state of the s MANAGE MANAGE A STATE OF THE STA a well . quite made and the same the section toattact | January Stant The state of the s The state of the state of 20 April 10 - 10 - 120 February 20 April 20 - 10 - 10 April 20 Apr Prince people where the second state of

17326

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17325

| | | | | | | | | | - | - | | |
|---------------|---|----------------------------------|-----------------|------------------------|------------|--|----------------|----------------------|-----------|------------|---------------------|-------------|
| 1. | PLACE OF DEATH a. COUNTY | | | | | 2. USUAL RESIDENCE (| | | UTW | | | |
| M | d. COONTI MO | ntgomery | | MARYL | AND | o. STATE Mar | ylan | d b. coul | M M | ontg | omer | У |
| | b. CITY OR TOWN (| f autside corporate limit | s, | c. LENGTH OF STAY IN | 1b | c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) | | | | | | |
| 1 | Be the sda | (pixe hearest town) | | 33 days | | Rockville | | | | | 5.1 | / |
| | | AL OR INSTITUTION (If no | ot in hospital, | give street address) | | d. STREET ADDRESS | | | | | e. IS RESIL | |
| | Naval Ho | spital | | | | 306 Readi | ng i | ave. | | | | NO X |
| 3. | NAME OF | | rst | Middle | | Last | 4. DAT | E Moni | th | Doy | Ye | 10 |
| | DECEASED (Type or print) | Hen | rbert (| C. ORAM | | | OF DEA | TH 12 | | 14 | 19 6 | 57 |
| S. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | □ 8 | . DATE OF BIRTH | 15 | 9. AGE (In years | IF UNDER | | IF UNDER | |
| Ma | ale | Cauc | WIDOWED | DIVORCED | 1 4 | SEPT 1895 | | lost birthdoy) | Months | Days | Hours | Min. |
| 100 | . USUAL OCCUPATION | (Give kind af wark dane | 10b. K | IND OF BUSINESS OR | | 11. BIRTHPLACE (County | & State, ar | foreign country) | | ITIZEN OF | | |
| dui | ing most of working | life, even if refired) | Ţ, | bustry filitary | | Massachuse | tts | | , | OUNTRY? | USA | |
| 13. | FATHER'S NAME | | 100 | | | 14. MOTHER'S MAIDEN I | | | | THE S | | |
| | I | nformation | not a | available | 1.3 | Inform | atio | n not avai | llabl | е | | |
| 15 | WAS DECEASED EVE | R IN U.S. ARMED FORCES? | 16. | SOCIAL SECURITY NO. | | | | ading Awan | 220 | | | |
| (1) | es, no or unknown) | Hyer give war of dates of | I service) | Not known | Le | ona Oram R | ockv | ille, Md. | | | | |
| | 1B. CAUSE OF DI | ATH (Enter only one cou | se per line for | (o), (b), and (c).) | | | | | | | ERVAL BET | |
| | PART I. DEAT | H WAS CAUSED BY: IMMEDIATE CAUSE | (o) BILA | ATERAL CONFI | LUEN | T LOBURLAR | PNEU | MONITIS | | ON: | SET AND D | DEATH |
| | 490 | DUE | . , | | | | | | | | | |
| | Conditions, if any, rise to immediat | which gave | (b) | | | | | | | | | |
| | stating the under | | TO | | | | | | | | | 5 11 |
| | lost. |) | (c) | | | | | | 130 | | | |
| N. | PART II. OTHER SI | GNIFICANT CONDITIONS C | ONTRIBUTING | TO DEATH BUT NOT RELAT | TED TO T | HE TERMINAL DISEASE COM | DITION G | IVEN IN PART 1(o) | | 19. | WAS AUTO PERFORM | DPSY ED3 |
| CATIC | | | | | | | | | | YE | | NO |
| CERTIFICATION | 20o. ACCIDENT WAS | UNDERLYING CAUSE OF DEATH | 20b. DI | ESCRIBE HOW INJURY OCC | URRED. (| Enter noture of injury in I | Port I ar I | Part II af item 18.) | | | - | |
| | | MEDICAL EXAMINER) | | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJU | JRY Manth, Doy, Yeor | | | | E OF INJURY (Hame, form | | . (City or tawn) | (C | ounty) | (| Stote) |
| ME | p.r | 10 | While of wor | | 10010 | ıry, street, affice bldg., etc.) | | | | | | |
| | 21. I certif | y that (I) (this has | pital) atten | ded the deceased fr | ram | 3 MOA 1 | 91 | tal4 DEC | , 19 | T, th | at (I) (v | we) las |
| | saw the de | eceased glive on 1 | i DEC | 1 <u>957</u> , ar | nd that | death accurred at | 1;00. | M, fram causes | and an | the date | stated | abave |
| | 220. SIGNATURE | | 1.1 | | | ATTENDING | MED. | STAFF | 22b. I | DATE SIGNI | ED | |
| | 0 | 2 lei | ly | | M.D | PHYS. | DIRECTOR | PHYS. L |] 16 | DECI | EMBEF | 8 67 |
| | 22c. PHYSICIAN'S NAME (Type) | E DEDITH | TCDD | MO TICH | | 22d. ADDRESS | CODT | TAT TOTAL | ace . | 2 4500 | | |
| | | TO IDIVIZIA | | | | A STATE OF THE STA | And the second | PAL, BETH | | | | |
| 230 | BURIAL, CREMATIC REMOVAL (Specify | | | 23c. NAME OF CEMETI | | | | LOCATION (City or To | | | (5 | tote) |
| | durial | 1-1-1 | | Parklawn (| Jeme' | | | kville, Ma | | | | |
| _ | I. FUNERAL DIRECTO | | | omeryADARES. | | 2So. REC'D | | | GISTRAR'S | | | |
| y: | son & Whe | eler, Rocki | ville. | Maryland | | DATE DE | 62 | 1 1967 | Cla | MEGO! | sade | 100 |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar to burial, (rematian, ar remaval, and in any event, within 22 bouls after death TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital or attending physician.

VR A15 (4)

to the neutron recognition and restriction of the property of THE RESERVE THE PROPERTY OF THE PARTY OF THE That topics the beautiful topic and the state of the stat

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 11321 | CERTIFICATE | OF DEATH | 1 | 7326 |
|---|----------------------------------|--|---|--|
| I. PLACE OF DEATH O COUNTY MONTGOME RY | MARYLAND | MARYL | Where deceased lived, if institution b. COUNTY | VIGOMERY |
| b. ČITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AROMA FARM d. NAME OF HOSPITAL OR INSTITUTION (If not in hospi | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If ou | tside corporote limits, write RURAL | ond give neorest town) / 5 / I.e. IS RESIDENCE |
| WASHINGTON SAN. | t thosp | 8105 | EASTERN AVA | ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) ARLEY | Middle OS | WALT | 4. DATE Month OF DEATH /2 - | 26 Doy Year 1967 |
| S. SEX 6. COLOR OR RACE 7. MARR FEMALE WHITE WIDOW | | 7- 1-86 | a last hirthday) A | FUNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min. |
| during most of working life even if retired) | S. KIND OF BUSINESS OR INDUSTRY | M155155 | | 12, CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME George Goff GSTA | | 14. MOTHER'S MAIDEN I | WHITE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ny, or unknown) (If yes give wor or dates of service) | 16. SOCIAL SECURITY NO. 17. III | NFORMANY PAGE OSE | 810 Address | ster Ave., S.S. |
| 1B. CAUSE OF DEATH (Enter only one couse per lipe PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. 1B. CAUSE OF DEATH (Enter only one couse per lipe PART I. DEATH WAS CAUSED BY: UNDER TO (c) | valeturos el | colerous Cor | wany Tarsuf | INTERVAL BETWEEN ONSET AND DEATH. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION 200. ACCIDENT WAS UNDERLYING 200. ON CONTRIBUTING CAUSE OF DEATH- | NG TO DEATH BUT NOT RELATED TO T | | ,,, | 19. WAS AUTOPSY PERFORMED? YES NO |
| I III CIITICA, NOTIT I MEDICAL CAMMINERI | | | | |
| Hour o.m. | | E OF INJURY (Home, form pry, street office bldg., etc.) | 0-101 | (County) (State) |
| 21. I certify that (I) (this haspital of saw the deceased alive an | | death occurred at | 9 <u>50</u> , ta <u>2 </u> | d an the date stated abave |
| 220. SIGNATURE Do no | roe M.D | PHYS. | MED. DIRECTOR D STAFF PHYS. D | 22b. DATE SIGNED 6/67 |
| 22c. PHYSICIAN'S NAME (Type) A. T. Mov | se | 22d. ADDRESS ON TO THE POPULATION OF THE POPULAT | well toe Tu | homavach mel |
| | 23c. NAME OF CEMETERY OR O | norial Park | 7110000000 | bissippi |
| Warner E. Pumphrey, Inc. | 2 8434 ADDRESSAGIA AL | 44.1 | BY REGISTRAR 25b. REGIS | Charles Judge. |

VR A15 (4) 25M 1/67

The Common of the supplier by the discuss of the control of the co 43811 MENTSONE PY TEXCOUNTED TO HASHINGTON SAW & TICSA WAS CARRY OF THE CAN APLEY COMMITTEE THE SE 16 28-1-8 62-1 X FEBRUARY SAMES 54912 6 NOTE SHEET THREE (BURE STREET

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS.

PRESTON STREET, BALTIMORE, MARYLAND 21201

| | MEDICAL EXAMINER'S C | CERTIFICATE OF DEATH | 17327 |
|-----------------|--|--|-------------------------------------|
| | PLACE OF DEATH a. COUNTY MARYLAND MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution of STAT Maryland b. COUNT | nontamery |
| | b. CITY OR TOWN (It outside corporate limits, write RURAL and give leavest town) C. LENGTH OF STAY IN 1b 26 mes | c. CITY OR TOWN (If our de carparote limits, write RURA | Land give neglest town) |
| - | d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) University Newsing Hemo | 1. 2800 Teaberry 9 | Poad YES NO NO |
| | NAME OF DECEASED (Type or print) MORRIS - PAREL | MAN OF DEATH DEC. | 24 1967 |
| S. | Male Cauc WIDOWED X DIVORCED [] 3 | 3/20/1882 85 yrs. | Manths Days Hours Min. |
| | On USUAL OCCUPATION (Give kind of work dane pring most of working life, even if retired) The state of the st | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT |
| 13. | Samuel Parelman | 14 MOTHER'S MAIDEN NAME (UNK) | 100 |
| | S. WAS DECEASED EVER IN U.S. ARMED FORCES? (es, na, ar unkylawn) (If yes give war ar dates of service) 16. SOCIAL SECURITY NO. 17. IN WKN ozer SAN | NUELTOPARELMAN 1060 | OY BUCKNELL DR |
| | 1B. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | irctory Failur | INTERVAL BETWEEN ONSET AND DEATH |
| | Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause (b) | rotic Heart D | isoase |
| | last. (c) | IF TERMINAL DISEASE CONDITION ON THE IN DATE AND | 19. WAS AUTOPSY |
| CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE | Terinselevases | PERFORMED? YES NO |
| L CERTIFICATION | CAOSE OF DEATH. | nter nature of injury in Part I ar Part II af item 1B.) | |
| MEDICAL | 2Dc. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19 2Dd. INJURY OCCURRED While Not While at wark at work | OF INJURY (Hame, farm, y, street, affice bldg., etc.) | (Caunty) (State) |
| | 21. I certify that I took charge of the remains described above, held death resulted from: Natural causes , Accident , Suicident | | and in my apinion |
| | ACTUAL SIGNATURE Delden Seaf | CHIEF MEDICAL EXAMINER | 22. DATE SIGNED |
| | NAME (Type) BELDEN R. KEAP. M. | | Ec, 24, 1967 |
| 230 | BO BURIAL, CREMATION, 23b. DAY THEREOF 23c. NAME OF CENTERY OR CR. BURIAL (Specify) 19/2/6/67, MT-Sharon | 118- 100/1601 | n) (County) (State) |
| 22 | ADDRESS O. C | | ISTRAR'S SIGNATURE |

DABEC 2

1967

A15ME (5) 6M 1/67

5 may be retained far yaur files.

the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page

TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, crematian, or remaval, and in any event within 72 hours after death.

necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to

TO DEPUTY MEUTIAL EXAMINER: This certificate should be executed within 24 hours after death. If

Active so to common delle se service il respensibilità delle se service. THE PERSON OF TH Land of the state MORRES LA PHISLARY DELL 24 6 MARCHES SERVICE SERVICES SERVICES The same with the same of the same of the same Continue rendered line then the Store Sand Draftship Site Washington ESTERED TO MEAN MILL TO THE CORNER TO X TEEC, RY 1967

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| Mir. | 0 | 00 | DIVISION | VI | SIMILIBITIONS | KEDEMICH | MILE | KECOKDO, | | *** | | 011 | |
|------|---|----|----------|----|---------------|----------|------|----------|----|-----|----|-----|---|
| d | 3 | 29 | | | | A | C | ERTIFICA | TE | OF | DE | AT | H |

| | 71000 | | At a | CEKIIF | ICATE | OF DEATH | | | 17 | 328 | | |
|-----------------------|--------------------------------------|---|------------------------------|---------------------------|------------|--|-----------------------|---------------------|-----------------|-------------|------------------------|----------|
| | PLACE OF DEATH o. COUNTY | MONTGOMER | v | MARY | LAND | 2. USUAL RESIDENCE (V o. STATE | | | titution: Resid | lence befor | e odmissi | on) |
| - | b. CITY OR TOWN (I | f outside corporate limit | | c. LENGTH OF STAY II | | c. CITY OR TOWN (If ou | | orote limits, write | RURAL ond | ive neores | t town) | |
| | SILVER | give nearest town) SPRING | | | | Wasl | hing | ton, D | . C. | | 47 | 7.3 |
| | d. NAME OF HOSPITA | AL OR INSTITUTION (If no | ot in hospitol, gi | ve street oddress) | | d. STREET ADDRESS Wa | ashi | ngton, | D. 0 | | e. IS RESII ON A F | DENCE |
| _ | | E NURS. & C | CONV. CI | | | 4000 Mass | s. A | | | | YES 🗌 | ХХои |
| 3. | NAME OF ELI | zabeth (BE | rst TTY Boi | Middle bman | | PARTS | 4. DATE OF DEAT | | Month | Doy 12 | Ye 19 | 67 |
| S. | 1 11 7 | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 1 8 | . DATE OF BIRTH | | 9. AGE (In year | | ER 1 YEAR | IF UNDER | |
| FI | EMALE | WHITE | WIDOWED | DIVORCED | | 11/11/02 | | last birthdov | rs. Months | Doys | Hours | Min. |
| | ing most of working | | | D OF BUSINESS OR USTRY | | 11. BIRTHPLACE (County | | | | CITIZEN OI | | |
| 13 | Housew FATHER'S NAME | lie | | | | Philade | | a, Pa. | | U.S | . A . | |
| 10. | | s Bobman | | | | | know | n | | | | |
| | WAS DECEASED EVE | R IN U.S. ARMED FORCES? | | OCIAL SECURITY NO. | 17. 11 | FORMANT | | | ddress Si | 1. | Spr. | Md |
| (Ye | no, or unknown) No | (If yes give wor or dotes None | of service) 579 | -58-8043 | R | bert Par | is | 900 0 | lintw | | | |
| | | ATH (Enter only one cou | use per line for (| o), (b), ond (c).) | | 0 0 000 | do | + | | INT | ERVAL BET SET AND D | DEATH, |
| | 221V | IMMEDIATE CAUSE | | ing-va | acu | lar acci | ecer | 1 | | I MA | 1= D14 | TK |
| | Conditions, if ony, | DUE | (| 0-01 | 2.7. | 11-Acler | - | | | | S | |
| | rise to immediat | | 1"/ | evise. | oner | M. ACCOL | 1000 | | | 1 | 7 443 | |
| | stoting the under | rlying couse | | | | | | | | | | |
| | lost. | ONIFICANT CONDITIONS | (c) | DEATH BUT NOT BEI | ATED TO T | UF TERMINAL DISEASE CON | IDITION CI | IVEN IN DART 1/- | 1 | 110 | WAS AUT | O.DCV |
| ATION | PART II. UTHER SI | GNIFICANT CONDITIONS C | ONIKIBUTING TO | DEATH BUT NOT KED | AIED IO I | HE TERMINAL DISEASE (ON | NOTITION G | IVEN IN PAKT IQO |) | | PERFORM ES | NO D |
| MEDICAL CERTIFICATION | | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY OF | CCURRED. (| Enter noture of injury in I | Port I or P | Port II of item 18 | .) | | | |
| MEDICA | 20c. TIME OF INJU Hour o.r p.r | 10 | 2Dd. IN. While of work | Not While of work | | E OF INJURY (Home, form ry, street, office bldg., etc.) | | . (City or town | 1) (| County) | | (Stote) |
| | 21. I certi | fy that (1) (this hos | spital) attend | ed the deceased | fram | 1950 ,1 | 9, | ta_bec | 11/11 | 967, 11 | nat (1) (| we) last |
| | | eceased alive on_ | | 11 19 67, | ond that | death occurred of | 22 | _M, from cou: | ses ond on | the dat | e stote | d obove. |
| | 220. SIGNATURE | .00 | 00 | | 0.50 | ATTENDING 🙀 | MED. | STAFF | 22b. | DATE SIGN | IED | 770 |
| | | Lectory | Kolus | | M.D | . PHYS. | DIRECTOR | PHYS. | □ 12 | 2-12- | 67 | |
| | 22c. PHYSICIAN'S NAME (Type | | ROBINS | | | 22d. ADDRESS 2480 16t1 | h St. | , N. W. | , Wash | 1., D | . C. | |
| 230 | BURIAL, CREMATIC | ON, 23b. DATE TH | | 23c. NAME OF CEME | TERY OR C | REMATORY | | LOCATION (City of | | (County | , | itote) |
| 1 | Burial Specify | 12/14 | +/67 | Rooseve | 1t (| Cemetery | P | hilade | lphia | , Pa | 1. | |

ADDRESS

2Sa. REC'D BY REGISTRAR

DATE DEC

REGISTRAR'S SIGNATURE

2Sb.

196

10 HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours aft Page 4 may be retained by the hospital or attending physicion. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the ottending physicion and completely filled in by a director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Poshould be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72-bours 9 VR A15 (4) 20 M 1/66

24. FUNERAL DIRECTOR

Goldberg Funeral

after death

e dispersion Control of the Notice Control Charles the South Land Co. Co. of the Co. of

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17329

| TOUR | CERTIFICATE OF DEATH |
|---|--|
| de de de | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed liyed, if institution: Residence before admission) |
| | a. COUNTY - Starte - |
| ges after | MARYLAND I LETY and MARYLAND |
| Pages Urs afte | b. CITY OR TOWN (t) outside corporate limits, c. LENGTH of STAY IN 16) c. CITY OR TOWN (If outside corporate limits, write RURAL and give negres town) |
| by Pour | Betties da II. V. H. Still - Chase Hvenue |
| . F. S. F. | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) do STREO ADDRESS |
| P 9 7 9 9 | The state of the s |
| 票 g 洼 | D'a burban Defles da VES NO |
| ×i vi | 3. NAME OF DECEASED First Middle log 4. DATE Month Doy Year OF |
| orb | (Type or print) Harry DEATH DEATH Sec. 3/ 196/ |
| npl ver | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF 18 PAGE (In yeors I FUNDER 1 YEAR I FUNDER 24 HRS. |
| y e | male when to widowed Divorced TERAS 1919 lost birthdoy) Months Doys Hours Min. |
| uo ou | |
| e a | 100. USUAL OCCUPATION (Bive kind of work done during most of working life, even if retired) 100. KIND OF BUSINESS OR HPLACE County & Stote, or foreign county & Stote, or foreign county & Stote, or foreign county? 11. CITIZEN OF WHAT COUNTS ? |
| Sas | Mantes Continent NIULIA TO SANTENO and M.D. IT |
| ysi -c | 73. FATHER'S NAME / 14. MOTHER'S MAIDEN NAME |
| e by o | Tidney Tatten Bottle : |
| 한 표 표 | a factor of the |
| , E = ; | 15. WAS DECEASED EVER IN U.S. ARKEET FORCES? (Yes, no, or unknown) (If yes, one wor or dotes of service) 16. SOCIAL SECURITY NO. Address Address |
| erm n, c | Mis Armywith Wife Elizablth Valles. |
| physician. signed by the ottending physicion and completely filled in by the burial-transit permit. Then please remove corbon papers. Pagburial, cremation, or removol, and in any event, within 72 hours | CAUSE OF DEATH (Enter only one-fluse per line for (o), (b), and (c).) INTERVAL BETWEEN |
| th usit | PART I. DEATH WAS CAUSED BY IMMEDIATE GAUSE (0) MYOCAR BIAL INFARCTION ONSET AND DEATH |
| do. | 4 201 DUE TO |
| sici ed al-1 ol, | Conditions if any which gave |
| physician signed by burial-tra buriol, cre | rise to immediate course (a) |
| o b | stoting the underlying couse DUE TO |
| nding been s the ior to | lost. (c) |
| 0 v 0 = | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY |
| or offer te hos use os alth pri | PERFORMED? YES NO NO CONTRIBUTION COLOR OF DEATH OF CONTRIBUTION COLOR OF DEATH OF CONTRIBUTION COLOR NOT |
| ospitol or certificate hed for us or. of Healt | YES NO NO |
| ficol for for f He | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) |
| ertified the | (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) (City or town) (County) (Stote) |
| e D the | Hour o.m. While Not While foctory, street, office bldg., etc.) |
| l by the hospitol After this certific I be detoched fo State Dept. of H | p.m. 17 of work |
| T 4 T 0 | 21. I certify that (1) (this hospital) attended the deceased from 3000, 1950, ta dee3 (, 1967, that (1) (we) last |
| be retoined DIRECTOR: / ge 3 should led with the | saw the deceased alixe an |
| ま ら を走 | 220. SIGNATURE 22b. DATE SIGNED 22b. DATE SIGNED |
| d w | M.D. PHYS. DIRECTOR D |
| - B7E | 22c, PHYSICIAN'S 13 FZ THES OLD |
| SA S | NAME (Type) ISIR. LEO DONOVAN JAIS WISCONSIN AR |
| Poge 4 moy O FUNERAL D director, pag Should be fill | |
| direct direct | 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) |
| 2000 | Burial 1-5-68 Baltimore Natl Cem. Baltimore, Maryland |
| W I | 24. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE |
| VR A15 (4) (4) 25M 1/67 | ROBERT A. PUMPHREYK Bethesda, Maryland DAMAN 5 1968 Journey |
| () | 1 21411 0 1000 1 1 1 |

3.1 17330

West and development and the state of the st 17329

the bear of the party and the

"pending" in pencil in Item 18. Give Pages 1,

the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm

necessary, please execute the certificate, writing the ward

Health priar to burial, crematian, or remaval, and in any event within 72 hours after death.

TO DEPUTY MEUTCAL EXAMINER: This certificate should be executed within 24 hours after death. If

17331

MARYLAND STATE DEPARTMENT OF HEALTH W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **DIVISION OF VITAL RECORDS, 301**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| MEDICAL EXAMINER 3 | CERTIFICATE OF DEATH 17330 |
|--|--|
| 1. PLACE OF DEATH o. COUNTY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE b. (COUNTY |
| b. CITY OR TOWN (If outside orparate limits, write RURAT and give pearest fown) | c. CITY OR TOWN, (If autside corparate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO IX |
| 3. NAME OF First Middle DECEASED (Type or print) Home, This large for the first form of the first form | Lost 4. DATE Month Day Year OF DEATH 22 1967 |
| | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Haurs Min. Yrs. |
| 10a. USUAL OCCUPATION (Give kind of wark dane during most of warking life even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CIVIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME (1) Ince L ferminter | 14. MOTHERS MAIDEN NAME STOCK der |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates of service) 16. SOCIAL SECURITY NO. | Torother Terminal Same. |
| IB. CAUSE OF DEATH (Enter anly one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO DUE TO | INTERVAL BETWEEN 20NSET AND DEATH |
| last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| PRIMARY or CONTRIBUTING CAUSE OF DEATH. | (Enfer nature of injury in Part I or Part II of item 1B.) |
| | CE OF INJURY (Hame, farm, large, street, affice bldg., etc.) 20f. (City or town) (Caunty) (State) |
| 21. I certify that I took charge af the remains described obave, he | eld on Autopsy , Inspection , Inquiry , ond in my apinion cide , Homicide , Undetermined manner . CHIEF MEDICAL EXAMINER . M.D. ASSISTANT MEDICAL EXAMINER . DEPUTY MEDICAL EXAMINER . Address (Street, city, tawn, ar county) |
| 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR REMOTE SECTION 14/26/67 | |
| 24. FUNERAL DIRECTOR WOULDERS CO. SURSH, D. C. | DATE DEC 2 9 1967 Clarify Sudges |

VR A15ME (5) 6M 1/67

TOTAL SUMMAND AND DESCRIPTION OF THE PROPERTY OF THE PROPERTY

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17332

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL&RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

GERTIFICATE OF DEATH

17331

| -4 | | | | | | | 110 | 31 | |
|------|---------------|--|--|--------------------------------------|-------------------------------------|------------------------------------|-----------------------|---------------------------|-------|
| н | | PLACE OF DEATH | | ^ | | nere deceosed lived, if institut | | fore odmission | 1) |
| | 1 | o. COUNTY | intagm ery | County MARYLAND | O. STATE MAY | uland b. coul | Man. | taame | ·NU |
| Н | | b. CITY OR TOWN (I | f outside corporate limits, | C. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outs | ide corporate limits, write RUI | RAL ond give neo | | 1 |
| | | write RURAL and | give nearest town) | 6 days | 1:19 | in a Spring | Max | ulan | XI / |
| П | | d. NAME OF HOSPIT. | AL OR INSTITUTION (If not in | hospitol, give street oddress) | d. STREET ADDRESS | iel Spring | 11101 | e. IS RESIDE | ENCE |
| 7 | | 11/2/ | 1 / | 11 . 1 1 | 8811 Co | lesville Pr | | ON A FAI | RM? |
| | 2 | NAME OF | 1 Cross | Mospital | 1 0011 | 0.7. | a. | | NO L |
| | | DECEASED | First | Middle | OI 11 11 | 4. DATE Mont | | oy Year | |
| | S. 9 | (Type or print) | OTUTA TO STATE OF THE PROPERTY | | hilpoti | DEATH DEC | I IF UNDER 1 YEAR | 19 6 | |
| | 5. | SEA | / 1 | MARRIED NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | Months Doy | | Min. |
| | _ | P. | | VIDOWED DIVORCED | 12/8/09 | 63 yrs. | | | |
| Н | | . USUAL OCCUPATION ing most of working | (Give kind of work done life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & | State, or foreign country) | 12. CITIZEN COUNTR | | |
| | | 14 | ouse Wite | | renns | ylvania | COONIN | 0.5 | |
| | 13. | FATHER'S NAME | | | 14. MOTHER'S MAIDEN NA | ME | | | |
| | | H.E. | LERNER | | MAY RIS | TON | | | |
| | | | R IN U.S. ARMED FORCES? (If yes give wor or dotes of ser | Vasion | INFORMANT | Addre | ess | The n | |
| | (16 | S, HO, OF UIIKIOWII) | (ii yes give wor or doles of ser | Vice) / | TAROLD M. F | HILPOTT-SE | ELIEM | 2. | |
| | | 18. CAUSE OF DE | ATH (Enter only one couse p | | 11 4 / | | | NTERVAL BETW | VEEN |
| | | PART I. DEAT | H WAS CAUSED BY: IMMEDIATE CAUSE (o) | Acute lumphi | tic leukou | N/C | | ONSET AND DE | ATH. |
| | | 2001 | DUE TO | - Jungary | | # w | 9 | | |
| | | Conditions, if ony, | | Lummosarce | ma | | / | 5 m | 75. |
| | | rise to immediate | | 7 | | | | - /// | 1001 |
| | | last. | (c) | | | | | | |
| | | PART II. OTHER SIG | | RIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE COND | ITION GIVEN IN PART 1(a) | 11 | 9. WAS AUTO! | PSY |
|) | TON | | | | | THE THE TALL | | 9. WAS AUTOF PERFORMET | D? |
| fan. | CERTIFICATION | 20o. ACCIDENT WAS | UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter nature of injury in Po | art Lor Port II of item 18) | | 152 N | |
| | ERT | OR CONTRIBUTING | CAUSE OF DEATH | 200. DESCRIBE 11047 INSORT OCCORRED. | . (Littlet Hotote of Hillory III Fo | is tot fort it of item to.) | | | |
| | | (IF EITHER, NOTIFY | MEDICAL EXAMINER) IRY Month, Doy, Yeor | 20d. INJURY OCCURRED 20e. PL/ | ACE OF INJURY (Home, farm, | 20f. (City or town) | (County) | 10 | 1-1-1 |
| | MEDICAL | Hour o.n | 1, | | ctory, street, office bldg., etc.) | 201. (City of fown) | (County) | (3) | tote) |
| | | р.п | n. 19 | ot work U ot work U | 1 11-1- | 6 | (A) (A) | | |
| | | | and the same of th | attended the deceased fram_ | | 66 to 12/12 | 9, 196/ | that (I) (a | las |
| | | | eceased affive an | 19 6 /, and the | at death accurred at | M, fram causes | - | - fee | abave |
| | | 220. SIGNATURE | 42 | 2. 1 C/A | | NED STAFF | 22b. DATE ST | GNED / | 17 |
| | | 00. DUVELCIANIE | 1/1/0 | may 100 | PHYS. D | IRECTOR L PHYS. L | 1/2// | (16 | 1 |
| | | 22c. PHYSICIAN'S NAME (Type) | //c Tonn | and Cold M D | | lesville Rd | Sil | Snr. | Md |
| | | | C. Lenn | | | | | | |
| | 230 | BURIAL, CREMATIO REMOVAL (Specify) | | _ | | 23d. LOCATION (City or To | | nty) (Sto | ote) |
| | - | Remova | 1 12-19-19 | | | New Castle, I | | | |
| | .IC | FUNERAL DIRECTOR | ler's Sons. | Inc. 5130 Wisc. Axe | e. N. W. 250. 150 | BY REGISTRAN 96 25b. RE | GISTRAR'S SIGNAT | URE | - |
| | - | TO PAR TOWN | | Web DC | DATE | | | () 0: | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

THE TRANSPORT OF THE PERSON OF FOR OPERATOR TO PRINCE TO PRODUCE THE SECRET PRINCE TO SERVE TO SE MARKET I MAIN TO PRAINING and with the properties the same transfer and Party Chipatti and the the man time to be the formation of the contract of the contra . C. , E Graman · · · Alle ingle Delicion , mor straight a see

funeral director, ora be filed with

ter death. Page

UDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

ospital ar attending physician.

After this certificate has been signed by the ottending physician and campletely filled in beed far use as the buriol-transit permit. Then please remove carban papers. Pages I and

7333

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 CERTIFICATE OF DEATH

17220

| | | CERTIFIC | AIL OI D | L-XIII | | | Reg. Dis | No: | 2 /4 |
|---|---|--------------------------------------|---|--------------|------------------------|---|---------------------|------------------|--|
| 1. PLACE OF DEATH o. COUNTY | Montgomery | MARYLAND | 2. USUAL RESID | | ere deceosed | lived. If institution b. COUNTY | | e before a | dmission) |
| b. CITY OR TOWN (IF of RURAL and give near beth esd | outside corporate limits, write rest town) | c. LENGTH OF STAY IN 16 | c. CITY OR T | | itside corpor | rote limits, write R | URAL and g | ive nearest | town) |
| OR INSTITUTION | L (If not in hospital, give street | oddress) | d. STREET A | | Road | | | 0 | RESIDENCE ON A FARM? |
| | ban Hospital | | | 1 | | | | | |
| 3. NAME OF DECEASED (Type or print) | Jean | Middle R. | Pitzer | | 4. DATE OF DEATH | Mor | | Day 5 | 1967 |
| 5. SEX | 6. COLOR OR RACE 7. MARK | RIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF SIRTH | ı 18 | | 9. AGE (In years lost birthdoy) 89 yrs. | | | JNDER 24 HRS. Durs Min. |
| during most of working | (Give kind of work done 10b. og life, even if retired) | KIND OF BUSINESS OR IND | USTRY 11. BIRTHPL | | or foreign co | ountry) | 12. CITIZ | U.S | A. |
| At Hom 13. FATHER'S NAME Samuel Ri | xey | | 14. MOTHER'S | | Wise | | | | E |
| 15. WAS DECEASED EVER | IN U. S. ARMED FORCES? yes, give war or dates of service) | SOCIAL SECURITY NO. | INFORMANT | ie R. | Kevse | | ross8320 Ade | 26th | |
| Conditions, if ony gove rise to im couse (o), stoting the lying couse lost. | mediate Due TO | Myocardial Arteriosclero | tic heart | dise | ase | E CONDITION GIV | /en in part | 20 1(o) 19. V | yrs. |
| 20a. ACCIDENT WAS | CAUSE OF DEATH | CRIBE HOW INJURY OCCUR | RED. (Enter noture of | finjury in P | ort I or Port | 11 of item 18.) | | | ERFORMED? |
| O TO THE OF INJURY Hour o.m. p. m. | | Not while | PLACE OF INJURY (I foctory, street, office | | | or town) | (C | ounty) | (Stote |
| actual signature | A | 57, and that deal | th accurred at | 4830 | V Str | | nd an the stote) | date st | ne deceased ated abave DATE SIGNED |
| 220. BURIAL, CREMATION REMOVAL (Specify) Removal | | 22c. NAME OF CEMETERY Fairview Ce | | | | rion (City, town, | | | (Stote) |
| | signature er's Soms Inc Ave.N.W. Wash. | ADDRESS DC | | 24a. REC'D | 8Y REGIST | 1967 P | Clean | NATURE | Lee |

page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. may be retained by VS A15 (4) 15M 9/58

and the man annulus service of photos tell to a service of the service of Service and the Authority of the E hartos di cometa pitanto agorizio di la se AS IN THE STREET - Continue to place and a liquid to the liquid THE SHEWELD STREET STREET 100 8 7 100 A

urreral T and 2

death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17333

CERTIFICATE OF DEATH

| | PLACE OF DEATH | | | | 2. USUAL RESIDENCE (V | | ceased lived, if institut | ion: Reside | nce before | e admissio | in) |
|---------------|---|------------|---|------------|---------------------------------|-------------|------------------------------------|-------------|----------------|---------------------|----------|
| | Montgomery | | MAR | YLAND | o. SIAIE Mary | Land | b. (00) | NTY Mor | ntgor | nery | |
| | b. CITY OR TOWN (If outside corporate li | mits, | c. LENGTH OF STAY | IN 1b | c. CITY OR TOWN (If ou | itside corp | porote limits, write RU | RAL ond gir | ve neores | t town) | |
| | write RURAL and give nearest town) Bethesda | | | Testa | Bethesd | a | | | | 15 | = 1 |
| - | d. NAME OF HOSPITAL OR INSTITUTION (I | f nat in | hospital, give street address) | | d. STREET ADDRESS | | | | | e. IS RESID | |
| | | | , | - 94 | 6017 Neil | hoor | Drive | | | ON A F | |
| 2 | 6017 Neilwood Dr | | M. I.I. | | | | | 1 | | | NO D |
| | NAME OF DECEASED | First | Middle | | Lost | 4. DAT | | | Doy | Yes | |
| | | LARY | | | PLATT | DEA | | | 8 | 19 (| 1.1 |
| S. : | SEX 6. COLOR OR RACE | 7.1 | MARRIED NEVER MARRIE | | . DATE OF BIRTH | | 9. AGE (In years last birthday) | Manths | 1 YEAR Dovs | IF UNDER | Min. |
| I | Female White | W | IDOWED DIVORCE | | Aug. 30, 189 | 90 | 77 yrs. | Maitins | Doys | 110013 | mut. |
| | . USUAL OCCUPATION (Give kind of work do | one | 10b. KIND OF BUSINESS OR | 15 | 11. BIRTHPLACE (County | & State, a | r fareign country) | | ITIZEN OF | WHAT | |
| duri | ing most of working life, even if retired) HOUSEWIIE | | INDUSTRY | | Russ | ia | | 110 | DUNTRY? | A. | |
| 13. | FATHER'S NAME | | | | 14. MOTHER'S MAIDEN N | | | | | | |
| | Zalman Landow | | | 7 | | 2 | 2 2 | | | | |
| 10 | WAS DECEASED EVER IN U.S. ARMED FORCE | | 16. SOCIAL SECURITY NO. | 1 17 11 | Mollie | [| f f | | | | |
| (Ye | s, na, or unknown) ((If yes give wor or dat | es of serv | rice) | | | 933 | 2 Harvey ddd ver Spring | load | | | |
| Ù. | No | Dec 200 | 169-16-8259 | D Na | than Platt | Sil | ver Spring | , Mar | rylar | nd | |
| | 1B. CAUSE OF DEATH (Enter only one | cause pe | r line for (q), (b), and (c).) | | 1 | , | | | | ERVAL BET | |
| П | PART I. DEATH WAS CAUSED BY: | ISE (a) | Corona | 7 70 | Proseleo | 245 | Cleres | KP | ON: | SET AND D | EATH |
| | | OUE TO | 0 01 | 1. | / | | | | | | 1110 |
| | Canditians, if any, which gave | IN/ | Lax Hyps | even | sero de | aco | 000 | | 14 | 100 | |
| | rise ta immediate cause (a), | UE TO | - 10 | , | | - | | • | 11 | 1 | |
| | stating the underlying couse | | | | | | | | 1 | | |
| | | (c) _ | | | | | | | 110 | MAG ANT | DEN |
| 8 | PART II. OTHER SIGNIFICANT CONDITION | S CONTR | IBUTING TO DEATH BUT NOT REI | LATED TO T | HE TERMINAL DISEASE CON | NOITION G | GIVEN IN PART 1(a) | | 19. | WAS AUTO PERFORM | |
| CERTIFICATION | | | | | | | | | YE | S 🔲 | NO 🔀 |
| 三 | 20o. ACCIDENT WAS UNDERLYING | | 205. DESCRIBE HOW INJURY O | CCURRED. (| Enter nature of injury in I | Port I or | Port II of item 18.) | | | | |
| | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Yea | r | 20d. INJURY OCCURRED | 20e. PLAC | E OF INJURY (Hame, farm | 1. 20 | f. (City or tawn) | 100 | ounty) | (| Stote) |
| EP | Hour a.m. | | While Not While | | ry, street, office bldg., etc.) | | | | | | , |
| | p.m. | 19 | at wark L ot work L | , | 40 - 4 | 2/3 | // 20 | - 10 | / | | |
| | 21. I certify that (I) (this I | |) ottended the deceased | from_ | 5-24 | 96) | , to 12.5 | , 199 | zZ, th | ot (I) (| we) lost |
| | saw the deceased olive an | | 2.5 1967, | and that | death occurred of | 6. 1 | M, from causes | | | | obove. |
| | 220 SIGNATURE | , | 1 | | ATTENDING | MED. | STAFF | | DATE SIGN | | |
| | Dedon et | un | man | M.D | . PHYS. | DIRECTO | R PHYS. |] 12 | -9-19 | 967 | |
| | 22c. PHYSICIAN'S | - | | | 22d. ADDRESS 9 | 15 1 | 9th Street | N. | i. | | |
| | NAME(Type) Isidore | Shu | lman, M. D. | | Washingto | on, | D. C. | | | | 7.1 |
| 23n | BURIAL CREMATION, 23b. DATE | THEREOF | 23c. NAME OF CEM | ETERY OR C | REMATORY | | LOCATION (City or To | wn) | (County) | (5 | tote) |
| | REMOVAL (Specify) | | | | | | | | (| | |
| 24 | Burial 12-1 | U- 15 | ADDRESS | Memo | rial Park | BY PEC | Ils Church ISJRAR 1967 | CACADADIC | CLANATILA | Va. | - |
| | | | | | 250. KECU | O TO | 1 1961 | Con | 100 | udg | 4 |
| (70 | Idhere Funeral Va | mo | 4217 Oth Ct | 7.7 7.7 | DATE | UL | T IOOF / | | | 0 | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in Dr. The funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, crematian, ar remaval, and in any event, within 72 hours after death. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hause Page 4 may be retained by the hospital ar attending physician.

VR A15 (4) 20 M 1/66

THE RESIDENCE OF THE PARTY OF T

17335

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

SION OF VITAL RECORDS, 301 W. PRESION STREET, BALTIMORE, MART

| | 1600 | J | | CERTIFICATE | OF DEATH | | 173 | 34 |
|-----------------|---------------------------------------|--|-----------------------------|----------------------------|---|-------------------------------|-----------------------|----------------------------|
| 1. | PLACE OF DEATH | | | | 2. USUAL RESIDENCE (| Where deceased lived, if in | nstitution: Residence | before odmission) |
| | o. COUNTY MC | NT GO ME RY | | MARYLAND | o. STATE MARY | YLAND b. | COUNTY | ONTGOMERY |
| | b. CITY OR TOWN (| If outside corporate limits, | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If or | utside corparate limits, writ | te RURAL and give n | earest tawn) |
| | WIITE KUKAL OIL | d give nearest tawn) | | 14 DAYS | LAYT | TONSVILLE | | 15-1 |
| | d. NAME OF HOSPIT | AL OR INSTITUTION (If not in | haspital, g | ive street oddress) | d. STREET ADDRESS | | | e. IS RESIDENCE |
| | MONTG | MERY GENERAL | Hosp | ITAL | - | | | ON A FARM? |
| 3. | NAME OF | First | | Middle | Lost | 4. DATE | Month | Doy Year |
| | (Type or print) | Ros | ERT | LAMAR | PLUMMER | OF DEATH | 12 | 6 1967 |
| 5. | SEX | 6. COLOR OR RACE 7. | MARRIED | X NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In year | ors IF UNDER 1 Y | |
| | MA LE | WHITE | VIDOWED | DIVORCED | 10-13-92 | lost birthdo | oy) Months D | Poys Hours Mi |
| 100 | . USUAL OCCUPATION | (Give kind of work done | | ID OF BUSINESS OR | 11. BIRTHPLACE (County | & Stote, or foreign country) | 12. CITIZI | EN OF WHAT |
| dui | ring most of working RETIREI | | INL | CARPENTER | MARYLAN | 10 | COUN | ITRY? USA |
| 13 | FATHER'S NAME | | | | 14. MOTHER'S MAIDEN | NAME | | |
| | HOWARO | A. PLUMMER | | | R. IDA CRAS | WFORD | | |
| 15 | . WAS DECEASED EVE | R IN U.S. ARMED FORCES? | 16. 5 | OCIAL SECURITY NO. 17. 1 | NFORMANT | | Address | |
| | ES | (If yes give wor or dotes of ser | vice) | 18-10-8492 MI | EDICAL RECOI | RD DEPT. | | |
| | 331) | EATH (Enter only one couse p TH WAS CAUSED BY: IMMEDIATE CAUSE (o) _ DUE TO | /1 | (o), (b), and (c).) | las acció | lent-lease | la arter | ONSET AND DEATH |
| | Conditions, if ony rise to immediat | e couse (a) | | | | | | |
| | stoting the unde | | | | | | | |
| | last. |) (c) _ | | | | | | |
| N | PART II. OTHER SI | GNIFICANT CONDITIONS CONTR | RIBUTING TO | O DEATH BUT NOT RELATED TO | 0 0 0 | 1 _4 . 1 | / | 19. WAS AUTOPSY PERFORMED? |
| A E | Droncho | preumonia, | Diah | | | uphatic leu | | YES NO |
| L CERTIFICATION | | UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY OCCURRED. | (Enter noture of injust in | Port 1 or Port II of item 1 | 8.) | |
| MEDICAL | 20c. TIME OF INJI Hour 'o.r p.r | 10 | 20d. IN While of work | Not While foct | CE OF INJURY (Hame, form ory, street, office bldg., etc. | | vn) (Count | (Stote |
| | 21. I certi | fy that (I) (this haspita | I) attend | ed the deceased from | ,1 | 1965, to De | e 16,196 | 7 that (I) (we) |
| | saw the d | ceased alive an_ | ee 6 | 1967, and that | death accurred at | 303 PM, from cau | uses and an the | date stated abo |
| | 22a. SIGNATURE | rederich | 1) | norman M. | ATTENDING X | MED. STAFF DIRECTOR PHYS. | 22b. DATE | SIGNED -6-67 |
| | 22c. PHYSIČIAN'S NAME (Type | FREOERICK MC | OMAU | , M. D. | 22d. ADDRESS MEDICAL | CENTER, SAN | DY SPRING | , M _D . |
| 23 | D. BURIAL, CREMATIC | ON, 23b. DATE THEREO | F | 23c. NAME OF CEMETERY OR | CREMATORY . | 23d. LOCATION (City | or Town) (C | ounty) (Stote) |
| | BUT 121 Specify | 12-9-6 | 7 | Laytonsville | | Lavtonsvi | lle Mont | Md. |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Shauld be filed with the State Dept. af Health priar to burial, cremation, ar remaval, and in any event, withly 72 how Page 4 may be retained by the hospital ar attending physician. VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

24. FUNERAL DIRECTOR
Francis H. Barber

Laytonsville, Md.

250. REC'D BY REGISTRAR 1967

25h REGISTRAR'S SIGNATURE

DESTRUCTION OF THE PROPERTY OF

LINTEREST TARGET PACHENTER

HE CAN BE A LABOUR TO THE PERSON NAMED IN

R. HEARTERNEER

THE RESERVE OF THE PROPERTY.

the common of th

thei thort sid beareryad hariyenofyes | Id-2-SI | walishing Frincis E. Emer Martonaville, 24.

MARYLAND STATE DEPARTMENT OF HEALTH

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11

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17337

CERTIFICATE OF DEATH

17336

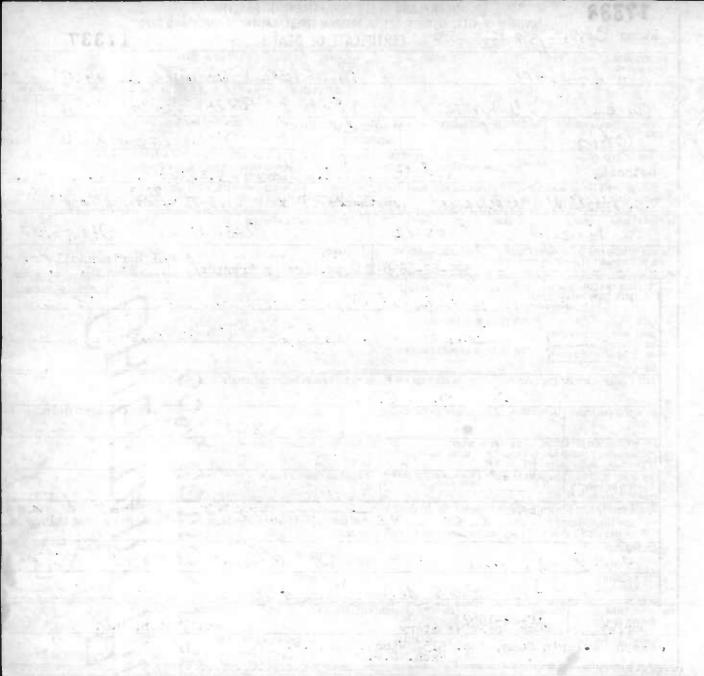
TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Poge 4 may be retained by the hospitol or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death.

| | PLACE OF DEATH o. COUNTY | | | | | 2. USUAL RESIDENCE (| Where dec | eased lived, if institution | | e before | e admission) |
|-----------------------|--------------------------------------|---|---------------|------------------------|----------|--------------------------------|-------------|-----------------------------|---------------------------------------|--------------|-------------------------------|
| | o. COUNTI | Montgom | ery | MARYLA | AND | Wes. | t Vir | ginia b. COUNT | I . | 6 | 201 05 |
| | b. CITY OR TOWN (| f outside corporate limits give nearest tawn) | | c. LENGTH OF STAY IN | lb | c. CITY OR TOWN (If or | utside corp | orote limits, write RURA | L and give | neares | t tawn) |
| | Beth | esda | | 29 Days | | Delbar | ton | | | | 753 |
| | d. NAME OF HOSPIT | AL OR INSTITUTION (If not | in hospitol, | give street oddress) | | d. STREET ADDRESS | | | | | e. IS RESIDENCE ON A FARM? |
| T | he Clini | cal Center, | Bethe | esda, Maryla | nd | Route | #1, | Box 1910 | | | YES X NO |
| | NAME OF DECEASED | Fire | st | Middle | | Lost | 4. DAT | E Manth | | Day | Year |
| | (Type ar print) | Harol | d | (NMN) | Pr | eece, Jr. | DEA | | | 26 | 19 67 |
| S. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | K B | DATE OF BIRTH 19 | 57 | | IF UNDER 1 | YEAR Days | Hours Min. |
| | Male | White | WIDOWED | DIVORCED | 0 2 | 22 Septembe: | r | 10 Yrs. | MOIIIIS | Duys | nouis min. |
| 100 | . USUAL OCCUPATION | (Give kind of work done | | (IND OF BUSINESS OR | | 11. BIRTHPLACE (County | & State, ar | fareign country) | | ZEN OF | |
| dur | ing mast af warking S t ud | ent | | NDUSTRY | | Wes | t Vir | ginia | (00 | USA | 1 |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN | | | - | | |
| | | Harold Pre | ece, S | Sr. | 1 | Pegg | y Sue | Runyon | | | |
| 15. | WAS DECEASED EVE | R IN U.S. ARMED FORCES? (If yes give wor or dotes of | 16 | SOCIAL SECURITY NO. | 17. 1 | FORMANT The M | | | 5 | | |
| | No | (ii yes give wor or dores or | zeivice) | None | | Clinical (| | | | ary | land |
| | 1B. CAUSE OF DI | EATH (Enter anly ane caus | e per line fo | or (a), (b), and (c).) | | | | | | INT | ERVAL BETWEEN |
| | | TH WAS CAUSED BY: IMMEDIATE CAUSE (| a) Aspi | iration, Pne | eumor | nia | | | | 48N | SEL AND DEATH Hours |
| | 2043 | DUE | TO | | | | | | | | |
| | Canditians, if any | | b) Gast | crointestina | l He | emorrhage | | | | 24 | hours |
| | rise to immediat stating the unde | | 10 | | | | | | | | |
| | last. |) | (c) Acut | te Lymphocyt | ic I | eukemia | | | | 40 | months |
| z | PART II. OTHER SI | GNIFICANT CONDITIONS CO | NTRIBUTING | TO DEATH BUT NOT RELAT | TED TO T | HE TERMINAL DISEASE CO | NDITION G | IVEN IN PART 1(a) | | 19. | WAS AUTOPSY PERFORMED? |
| MEDICAL CERTIFICATION | Miliar | y tuberculo | sis - | inactive. | | | | | | YI | ES X NO |
| TIFIC | 20a. ACCIDENT WAS | | 20b. D | ESCRIBE HOW INJURY OCC | URRED. (| Enter nature of injury in | Port I or I | Part II af item 1B.) | - | | |
| CER | | CAUSE OF DEATH MEDICAL EXAMINER) | | | | | | | | | |
| CAL | 20c. TIME OF INJU | JRY Manth, Day, Year | 20d. | INJURY OCCURRED 2 | | E OF INJURY (Home, farn | | . (City ar town) | (Cou | nty) | (State) |
| MED | Hour a.r | n. n 19 | While at wa | | focto | ry, street, office bldg., etc. |) | | | | |
| | 21 certi | fy that XIX (this has | | nded the deceased fr | rom 2° | November | 19 67 | to 26 Dec. | 19 6 | 57 th | nt XIX (we) las |
| M | | | | nber 19 67, an | | | | | | | |
| | 22a. SIGNATURE | DA. | 1 | 6.00 | | | MED PN | M. | 22b. DA | | |
| | . 7 | ukaid. | ¥. | Orell | M.D | | DIRECTOR | STAFF PHYS. | 27 D | ecen | nber. |
| - | 22c. PHYSICIAN'S | Distant II | 0 | -1- MD | | 22d. ADDRESSTh | e Cli | inical Cent | er, l | Nat: | Lona |
| | NAME (Type) | Richard H | · Ure | | | | es of | Health, E | | | |
| 230 | BURIAL, CREMATIC REMOVAL (Specify | | REOF | 23c. NAME OF CEMETE | ERY OR C | REMATORY | 23d. | LOCATION (City or Tow | | (Caunty) | (State) |
| | KEHOVE | | , | | | | | ACIDAL | , , , , , , , , , , , , , , , , , , , | _ | W. VZ. |
| 24 | FUNERAL DIRECTO | hambers C | à. INC | 1400 Cha | 6:4 | SY, NW 250. RECT | D BY REGI | STRAR 2Sb. REG | ISTRAR'S SI | | |

VR A15 (4) 25M 1/67

| | | 17338 MARYLAND STATE DEPARTMENT OF HEALTH |
|------------------------|---------------|--|
| 1 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17337 |
| XX | 1 0 | CERTIFICATE OF DEATH 17337 CEASED NAME First Middle Last 2a, DATE OF DEATH 2b, HOUR |
| A Table | | ype or print) LOGAN PRESICK DECEMBER 20 1967 N |
| s after c | 3. SE | |
| 1 | 70.1 | Male White Feb. 8, 1882 85 YRS. |
| | (001 | |
| 90 | 10. (| Bethesda 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during most of working life, even if retired.) All of the superior during most of working life, even if retired.) Lawyer- U.S. Gov't. |
| 47 | | USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER 3 38th St. NW |
| 3 | 14. 1 | ATHER'S NAME First Middle Presier Is. MOTHER'S MAIDEN NAME First MATH 11de Middle Herbert |
| | | WAS DECEASED EVER IN U.S. ARMED FORCES? es, no, ar unknown) (If yes give wor or dates of service) 16b. SOCIAL SECURITY NO. 17. INFORMANT 1086 Address Springknoll r. 579-62-6656-T Copt. Irving Presjer/ Potomac. No. |
| 200 | | 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) APPROXIMATE INTRIVAL BETWEEN ONSET AND OFATH |
| | | PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (0) Bilateral Bronchiale Preuminia 36 hours |
| Dollar, cresilians, at | | Conditions, if any, which gave) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave) |
| | | rise ta immediate cause (o), stoting the underlying couse DUE TO, OR AS A CONSEQUENCE OF |
| | | lost. (c) |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) |
| ^ | CERTIFICATION | 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING |
| 2 | ERTIFIC | YES NO (CAUSES OF DEATH? |
| | 3 | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CONTRIBUTING OR CONTRIBUTING OR CONTRIBUTING OR CONTRIBUTING P.M. Manth Day Year P.M. 19 |
| | MEDI | 21d. INJURY OCCURRED While Not while of work o |
| | | 220. I certify that (I) (this hospital) ottended the deceased from 1943, to 1943, to 1943, to 1943, that (I) (we) las saw the deceased alive an 1943, and that in (my) (per) opinion death occurred on the date and hour and from the |
| | | saw the deceased alive an 18 20 19 and that in (my) (per) opinion death occurred on the dote and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |
| | | 226, SIGNATURE 226, DATE SIGNED |
| | | P.P. analysician's Degree M. Degree Phys. Director Direct |
| | | NAME (Type) P.P. ANDREWS M.D WASHINGTON DC |
| | 230. | BURIAL, CREMATION, 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Caunty) (State) |
| | 24. | REMOVAL (Specify) Rock Creek Cenetery Washington, D.C. Flyera Drector Washington, D.C. Flyera Drector Washington, D.C. Flyera Drector Washington, D.C. Flyera Drector Washington, D.C. |
| 8 | | FUNERAL DIRECTOR WHEN'S Sons, Inc. 51300RESSWisc Ave. N. 26a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Wash. D.C. DATE DEC. 2.8 1967 (Charles Judges) |



dges I and 2 rs after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers, pages should be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 72 haurs after

VR A15 (4) 25M 1/67 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hooks Page 4 may be retained by the haspital ar attending physician.

after death

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | CEKTIFICATE C | OF DEATH | | 17338 |
|---|--|---|---|---|
| 1. PLACE OF DEATH COUNTY Monlanners | | O. STATE | deceosed lived, if institution | n: Residence before odmission) |
| b. CITY OR TOWN (If outside corporal limits, MID RURAL card give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give | 1 day | CITY OR TOWN (If outside Lengues) | corporote limits, write RURA | 15 I RESIDENCE |
| Suburban | | 10812 7 | obeon & | ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) | Middle // | Lost 4. | DATE Month OF DEATH /2 | 27 Year 27 1967 |
| S. SEX 6. COLOR OB-RACE 7. MARRIED WIDOWED WIDOWED | NEVER MARRIED 8. I | DATE OF BIRTH | 9. AGE (In years lost birthdoy) 70 yrs. | Months Doys Hours Min. |
| during most of working life, even if retired INDU | | Maryla County & Sto | te, or foreign country) | 12. CITIZEN OF WHAT |
| 13. FATHER'S MAME Price | | 4. MOTHER'S MAIDEN NAME | Elles | the 1 |
| 15. WAS DECRASED EVER IN U.S. ARMED FORCES? (Yes, no arupknown) (If you give wor or dotes of service) | CIAL SECURITY NO. 17. HITE | ormani Emela Fr | Address | Same |
| 18. CAUSE OF DEATH (Enter only one court per line for (a PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) |), (b), and (c).) NCHO PNEUMO. | NIA | | INTERVAL BETWEEN ONSET AND DEATH |
| 1 rice to immediate couse (a) | ESTIVE HE | ART FAI | LURE | 2 yrs |
| stoting the underlying couse DUE 10 | RIOSCUEROTIO | - HEART | DISEASE | 104Rs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO | DEATH BUT NOT RELATED TO THE | TERMINAL DISEASE CONDITION | DN GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? YES \(\square\) NO \(\square\) |
| OR CONTRIBUTING CAUSE OF DEATH | RIBE HOW INJURY OCCURRED. (Ent | ter noture of injury in Port | I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 White of work to | | OF INJURY (Home, farm, , street, office bldg., etc.) | 20f. (City or town) | (County) (Stote) |
| 21. I certify that (I) (this heapital) attende saw the deceased alive on 12/27 | d the deceased fram/ 1967, and that d | | 3, to /2/27 22M, from causes a | nd on the date stoted obove |
| 220. SIGNATURE John E. Ener | ett M.D. | | CTOR STAFF | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) JOHN E. EVER | PETT | Kensing to | 7. / | 400 CONN. AUE |
| 23o. BURIAL, CREMATION, REMOVAL (Specify) 12–30–1967 | 23c. NAME OF CEMETERY OR CRE | | 23d. LOCATION (City or Tow Suitland, M | , |
| 24. FUNERAL DIRECTOR | ADDRESS 5130 Wisc. Ave. | N.W 2So. REC'D BY | | SISTRAR'S SIGNATURE |

THE PERSON NAMED OF THE PERSON E66.1 Mary wash M. regiones section of it may the thoroughless autocher filter Februar St. aller & trade to the to m White Microflered House Eller TOWF Terms "IN 10 mis Tomales Their weeking the will have been a first the same and the same and a same and a same and

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | 2.10 | Q) ,4 P | | | | | |
|--|--|---------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence | e befare admission) | | | | | |
| Montgomery MARYLAND | o. STATE b. COUNTY Pennsylvania | | | | | | |
| b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If autside carparate limits, write RURAL and give | nearest tawn) | | | | | |
| write RURAL and give nearest tawn) Bethesda 72 days | Downingtown | 75-3 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE | | | | | |
| The Clinical Center, Bethesda, Maryland | R.D. #2 | ON A FARM? YES NO X | | | | | |
| 3. NAME OF First Middle DECEASED First A | Last 4. DATE Manth | Day Year | | | | | |
| (Type or print) Richard Andrew F | rzemyski, Jr. OF December | 3 1967 | | | | | |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 last birthday) Months | YEAR IF UNDER 24 HRS. Days Haurs Min. | | | | | |
| Male White WIDOWED DIVORCED | 23 December 1948 18 yrs. | Days Haurs Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of wark dane during most of warking life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | | ZEN OF WHAT | | | | | |
| Student None | England | USA | | | | | |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Richard A. Przemyski, Sr. | Eva Lada | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 (Yes, na, ar unknawn) (If yes give war ar dates of service) | . INFORMANTThe Medical Recordidatess | | | | | | |
| (7 es, ind, di diikild wil) ((il yes give wall di adies di service) | he Clinical Center, Bethesda, Ma | arvland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) | | INTERVAL BETWEEN | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) Silatteral | bronchopneumonia | DNSET AND DEATH | | | | | |
| 2043 DUE TO | | | | | | | |
| Conditions, if ony, which gove) (b) Septicemia with renal and perisplenic abscesses | | | | | | | |
| nise ta immediate cause (a), stating the underlying cause | | | | | | | |
| lost. (c) Acute myelogenous | s leukemia | 2 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY | | | | | |
| Cerebral edema (24 hours) | | PERFORMED? YES X NO | | | | | |
| 三 20a. ACCIDENT WAS UNDERLYING ロ 20b. DESCRIBE HOW INJURY OCCURRE | D. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | | |
| | | | | | | | |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. P | LACE OF INJURY (Hame, farm, 20f. (City or town) (Cau | nty) (State) | | | | | |
| Haur'a.m. p.m. 19 While Not While of work of work | actory, street, affice bldg., etc.) | | | | | | |
| 21. X certify that (1) (this hospital) attended the deceased from. | Sept. 22 1967 to Dec. 3 196 | 7 that (A) (we) las | | | | | |
| saw the deceased alive on Dec. 3, 1967, and the | not death accurred at 10:50M, fram causes and an th | e dote stated abay | | | | | |
| 22a. SIGNATURE | PM 22b. DA | TE SIGNED | | | | | |
| Naud L Mily | M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 4 De | cember 1967 | | | | | |
| 22c. PHYSICIAN'S | 22d. ADDRESS The Clinical Center, | National | | | | | |
| NAME (Type) David L. Lilien, MD | Institutes of Health, Bethes | da, Md. | | | | | |
| 23a. BURIAL, DEDMINISTRY, 23b. DATE THEREOF 23c. NAME OF CEMETERY C | | (Caunty) (State) | | | | | |
| Burial Dec. 7, 1967 St. Joseph's | | ster, Pa. | | | | | |
| | | | | | | | |
| 24. FUNERAL DIRECTOR Balston, 107 W. Lancaster | Ave. 250. REGISTRAR 1987 SIL | GNATURE | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after **TO FUNERAL DIRECTOR:** After this cerificate has been signed by the attending physician and campletely filled in by the director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pashauld be filed with the State Dept. of Health priar ta burial, crematian, ar removal, and in any event, within 72 haury Page 4 may be retained by the haspital ar attending physician.

after death the funera

VR A15 (4) 25M 1/67

WEEV I WATER THE TATER OF THE PARTY OF THE P the state of the s - Dec. 1, IMPER, Joseph - Charles of Thermite Dam, Charles, Ph. Friend W. And Land 107 W. Landerstein Co. Village and Market St. Vil

| tems 18&21 Fi | lm 396 | MARYLAND | STATE DEPARTMENT | OF HEALTH | |
|---------------|---------------|-------------------|-----------------------|----------------------------------|------|
| 12-28-67 ams | DIVISION OF V | /HTAL RECORDS, 30 | OI W. PRESTON STREET, | OF HEALTH BALTIMORE, MARYLAND | 2120 |
| 4 14 0 1 4 | | | | | |

| | 1734 | 1 | | CERTII | FICATE | OF DEATH | | | 17 | 34 | 0 | |
|--|--|--|-------------------------|--|----------------------|--|------------------|------------------------------------|--------------------------|----------------------------|-------------------------------|------------------------|
| | PLACE OF DEATH o. COUNTY Montgon | nery | | MAR | RYLAND | 2. USUAL RESIDENCE (V a. STATE New Yor | Where dece | eased lived, if institu b. COU | Ition: Residen | ce befar | admissic | on) |
| | b. CITY OR TOWN (| If autside corporate limit give nearest town) | s, | c. LENGTH OF STAY | | c. CITY OR TOWN (If au Brookly | itside corp | orote limits, write RI | JRAL and give | e neares | t town) | -3 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center (N. I. H.) | | | | | | d. STREET ADDRESS 630 E. | | Street | | | ON A FA | DENCE ARM? NO XX |
| 3. | NAME OF DECEASED (Type or print) | F | rst muel | Middle (NMN) | | lost Rappel | 4. DATI | E Mor | ember | Doy | Yec 19 (| or |
| | SEX Ma.le | 6. COLOR OR RACE White | | NEVER MARRIE | | . DATE OF BIRTH | | 9. AGE (In years last birthday) | IF UNDER Manths | 1 YEAR Days | IF UNDER | |
| 100 | | (Give kind of wark dane life, even if retired) | 10b. KI | ND OF BUSINESS OR DUSTRY | <u>. []</u> | November 1 11. BIRTHPLACE (County New Y | & State, ar | 55 yrs. fareign country) | CO | TIZEN OF JUNTRY? JSA | WHAT | |
| | | n Rappel | | | | 14. MOTHER'S MAIDEN M | | | | | | |
| | es, na, or unknawn) Yes | R IN U.S. ARMED FORCES? (If yes give war ar dates) 1943—45 | of service) | social security no. .6–07–7878 | 17. 11 Cen | FORMANTThe Me ter, Bethes | dica da, 1 | l Records Maryland | ^{ress} The 2001 | 4 | | |
| | | EATH (Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE DUE | (o) Caro | | Kévija | 'Arrhythmi | .8 | | | | ERVAL BET SET AND D day | |
| | Conditions, if any rise to immediat stating the unde last. | e cause (a), | TO Valv | cific Aort ve Replace eroscleros | ement | enosis, Pos | st-Op | erative A | ortic | | day | |
| ATION | PART II. OTHER SI | GNIFICANT CONDITIONS C | ONTRIBUTING 1 | O DEATH BUT NOT RE | LATED TO T | HE TERMINAL DISEASE CON | NDITION G | IVEN IN PART 1(a) | | 19. | WAS AUTO PERFORM | OPSY |
| IL CERTIFICATION | | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DE | SCRIBE HOW INJURY O | OCCURRED. (| Enter nature of injury in I | Part 1 ar F | Part II of item 18.) | | | | |
| MEDICAL | Hour 'o.r p.r | n. 19 | While at wark | c U ot wark U | facto | E OF INJURY (Home, form ry, street, office bldg., etc.) | | | | unty) | | (Stote) |
| | 21. I certing | fy that (1) (this has eceased alive an 1 | pital) attend Decemb | ded the deceased per 19 67, | fram_1 and that | 9 November 1 death occurred at | 967 2:15/ | tal Decem AM, Mrom causes | | | | we) last l abave. |
| | | nes c.c | 1. Du. | dis | M.D | PHYS. | MED. DIRECTOR | | 12/ | ate sign $1/67$ | | |
| | 22c PHY ICIAN'S NAME (Type) | | | chs, M. D. | | 22d. ADDRESS The Institute | S OF | Health, | Bethes | sda, | Md . 20 | 001/ |
| B | REMOVAL (Specify | 12-3- | | | Carm | el cemeter | y Br | LOCATION (City or To | Nen | (County) | ork | tate) |
| | ernaval Directo | nzansky <i>An</i> | d 504 | S WASh | 14th : | 200/0 DATE DE | C 4 | STRAR 1967 25b. R | Tour , | ATUR | Jane J | A. |

VR A15 (4) 25M 1/67

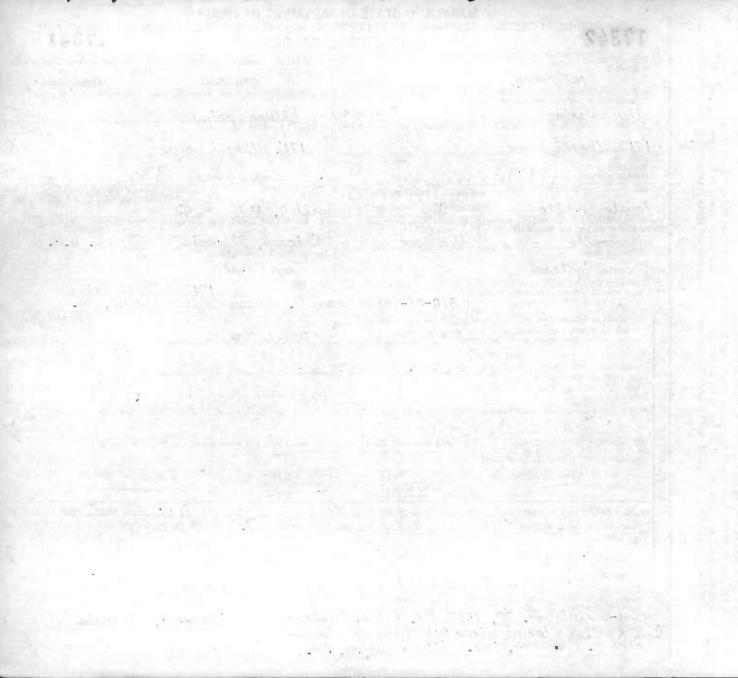
DINZANSKY AND SOMS

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COCCUR CONTROL MORAL METALLICATION CONTROL AND COCCUR CONTROL OF THE CONTROL OF T

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Tontaomeru Montaomeru MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Opring uears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) bon paper within 72 e. IS RESIDENCE ON A FARM? NO YES completely 3. NAME DE First Middle DATE Month Year DECEASED (Type or print) US DEATH 5. SEX 6. COLOR OR RACE OATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIEO last birthday) Months I Days and Temale. WIDOWED OIVORCED [9 92 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INOUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? ousewite. Own Home 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME remova attending principles Thomas Podlesak Anna Cesal 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes pive war or dates of service)] 16. SOCIAL SECURITY NO. | 17. INFORMANT 0 Frank (cremation, Kousch. wer opring. the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH signed by ourial-transit PART I. DEATH WAS CAUSED BY: attending physician. E wound **OUE TO** Cenditions, if any, which (b) peen gave rise to Immediate **OUE TO** cause (a), stating the underlying cause last. ICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMEO? certificate 0 NO IS YES 20a. ACCIDENT WAS UNDERLYING OESCRIBE HOW INJURY OCCURREO. (Enter nature of Injury In Part I or Part II of Item 18.) 00 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) he is ac MEDICAL 20c. TIME OF INJURY Month, Oay, Year 20d, INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, I 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After While Not While p.m. at work at work P 21. I certify that (!) (this hospital) attended the deceased from 196 DIRECTOR: and that death occurred at M. from the causes and on the date stated above. saw the deceased alive on. 3 showith 22a. SIGNATURE 22b. OATE SIGNEO ATTENOING M.O. pa TO FUNERAL PHYSICIAN'S director, p ADDRESS NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) 25a. REC'O BY REGISTRAR Avenue VR A15 (4) 20M 1/65



Page 4 may be retained by the haspital or attending physician.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17342

| 1. PLACE OF DEATH o. COUNTY | | | O STATE | Where deceosed lived, if institution: R | Residence befare admission) |
|--|--|--|----------------------------|--|---|
| Mon | taomery | MARYLAND | Mary | land | Montgomery |
| b. CITY OR TOWN | If outside corporate limits, d give negrest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If o | utside corporote limits, write RURAL or | nd give neorest tawn) |
| Sil | ver Spring | | Penn Sh | iop Road Route | 3 15-1 |
| | AL OR INSTITUTION (If not in h | aspital, give street address) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| | l Villa | | | | YES NO |
| 3. NAME OF DECEASED (Type or print) | First Ralph | Middle | Reece | 4. DATE Month OF DEATH Decembe | 29 19 67 |
| S. SEX | 6. COLOR OR RACE 7. N | MARRIED NEVER MARRIED | B. DATE OF BIRTH | | UNDER 1 YEAR IF UNDER 24 HRS. nths Days Hours Min. |
| Male | white W | DOWED DIVORCED | 4-17-91 | 86 yrs. | nths Days Hours Min. |
| 10a. USUAL OCCUPATIO during most of warking Deaman | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County | 8 State, or fareign country) New Dersey | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME | noun | | 14. MOTHER'S MAIDEN | | |
| | ER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. | INFORMANT | Address 5 | 000 (J. · II PI |
| | (If yes give wor ar dates af servi | ice) | Miss Elean | 10 | 5 m / 2.0.00 5 5 /001 |
| Tan CAUSE OF D | TATIL (T-A-) | 1 105-07-7004-11 | 1116.000 6 . 10.0110 | nech mech | anicabura Pa. |
| | EATH (Enter anly ane cause per TH WAS CAUSED BY: | | 10.1.11 | 0 - 1 - | ONSET AND DEATH |
| 151X | IMMEDIATE CAUSE (a) | Massive gasquoi | m testina 1 | sleeding | \$ |
| Conditions, if ony | DUE TO | Recurrent CAS | stowach u | with liver & mo | do 6 mas |
| rise ta immedia | re cause (a), | Bearieff: Cit's | 3101000010 | 7,000 | |
| stating the unde | riving couse | metastasco | | | |
| - Constraints |) (c) | DUTING TO DEATH BUT NOT BELATED TO | THE TERMINAL DISEASE CO | NOTION CIVEN IN DADT 1(-) | 10 WAS AUTODSY |
| PAKI II. UINEK S | GNIFICANT CONDITIONS CONTRI | BUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CO | NUTTION GIVEN IN PART I(0) | 19. WAS AUTOPSY PERFORMED? YES NO M |
| 20g. ACCIDENT WA | C HAIDEDI VING [7] | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter pature of injury in | Part I as Part II of item 10) | YES NO K |
| OR CONTRIBUTING | CAUSE OF DEATH MEDICAL EXAMINER) | ZUD. DESCRIBE HOW INJURY OCCURRED. | (Enter holore of injury in | run i ur run ii oi nem ib.) | |
| 20c. TIME OF INJ | | While Not While fac | ACE OF INJURY (Hame, farr | | (Caunty) (State) |
| р. | m. 19 | at wark at wark | No. 2 2 0 | 10/7 / 12/20 | 10/7 11 11/11/11 |
| saw the d | eceased alive on | oftended the deceased from_ 1967, and the | | 1967, ta 1230 1100 M, from causes and | , 19 <u>67</u> , thot (I) (we) last an the dote stoted above |
| 22a. SIGNATURE | une H. Bo | endla m | .D. ATTENDING D | MED. STAFF DIRECTOR PHYS. | 2b. DATE SIGNED 12-30-67 |
| 22c. PHYSICIAN'S | | | 1 22d ADDRESS | | |
| NAME (Type | Benne G. Be | endler, M. D. | 10850 G | a. Ave Wheaton | m 4 |
| 23a. BURIAL, CREMATI REMOVAL (Specify | | 23c. NAME OF CEMETERY OR | CREMATORY | 23d. LOCATION (City or Town) | (County) (State) |
| cremati | on Dec. 30. | 1961 Fort Lincol | | Price George | Manuland |
| 24. FUNERAL DIRECTO | R Wisor Clock | weren ADDRESS | Venue 250. KA | MBY REGISTRA 968 25b. PEGISTA | MES BYAT BEEFE |
| Mannon 8 | Pumphasu In | 24.14 yeargra | DATE | 7 | 00 |

PROTECTION STATES ARE MADE AND A STATE OF THE COURSE OF THE PROTECTION OF THE PROTEC MAEVI STRUCKSON THE TRUCKSON AND MALESTAN CONTRACTOR Arthurst a Line Province of the Aviscary THE PERSON NAMED IN THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUM U Sagna D. Bandler, D. T. 10882 and ave stantonyo

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17343

| 102 | 7-4 | | AIL OF BLATTI | | | | |
|--|--|--|--|---------------------------------------|---|--|--|
| PLACE OF DEATH O. COUNTY | 7 | | | | tion: Residence before admission) | | |
| o. Coonii | Mentem | MARYLA | NO O. STATE Mare | Iland b. Coll | non Tax | | |
| b. CITY OR TOWN | (If outside corporate limits, | c. LENGTH OF STAY IN | b . C. CITY OR TOWN (IF & | tside corporote limits, write RU | RAL and give mearest town) | | |
| Write KURAL of | Delate County | 27 days | 2 Rt #3 | Mitheraluse | 151 | | |
| d. NAME OF HOSPI | TAL OR INSTITUTION (If not in | hospital, give street address) | d. STREET ADDRESS | 1 10 | e. IS RESIDENCE | | |
| | Suha | rhan | 12824 | Jern Dru | ON A FARM? YES NO | | |
| 3. NAME OF DECEASED (Type or print) | Edno | Grace | Reed | 4. DATE Mont | 1 1 200 1- | | |
| S. SEX | 1.11 | MARRIED NEVER MARRIED VIDOWED DIVORCEO | 1 8. DATE OF BIRTH 1 Quq. 24-189 | 9. AGE (In years last birthdoy) | Months Doys Hours Min. | | |
| during most of working | N (Give kind of work done life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY Secution of Management of the security of th | 19. BIRTHPLACE (County | & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME | Soper | | 14. MOTHER'S MADEEN | Priscilla) | thite. | | |
| 1S. WAS DECEASED EV (Yes, no, or unknown) | ER IN U.S. ARMED FORCES? (If yes give wor or dotes of ser | 16. SOCIAL SECURITY NO. 014-32-9743 | Ms alnutt | 2824 Jern | Ess (daughter | | |
| 18. CAUSE OF E | EATH (Enter only one couse p | er line for (o), (b), ond (c).) | 1 | | INTERVAL BETWEEN | | |
| PART I. DE | TH WAS CAUSED BY: IMMEDIATE CAUSE (o) _ | Carcinoma of P | ancreas | | ONSET AND DEATH | | |
| 13/1 | 13 / A DUE TO | | | | | | |
| Conditions, if on | | | | | | | |
| rise to immedio | | | | | | | |
| last. | (c) | | | | | | |
| PART II. OTHER S | IGNIFICANT CONDITIONS CONTI | RIBUTING TO OEATH BUT NOT RELATI | D TO THE TERMINAL OISEASE CON | NDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? YES X NO | | |
| OR CONTRIBUTING | S UNOERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. OESCRIBE HOW INJURY OCCU | RRED. (Enter noture of injury in | Port I or Port II of item 18.) | , C33 to | | |
| Hour o | URY Month, Doy, Yeor m. m. 19 | 2Dd. INJURY OCCURRED While Not While ot work of work | De. PLACE OF INJURY (Home, form foctory, street, office bldg., etc.) | | (County) (Stote) | | |
| | ify that (I) (this hospital | 1) attended the deceased from | am/2/8, 1 d that death accurred at | 9 67, to 12/28 1125 M, fram couses | 7, 1967, that (I) (we) la and an the date stated above | | |
| 220. SIGNATURE | vlege. | nulario | M.D. ATTENDING PHYS. | MED. STAFF OIRECTOR PHYS. | 22b. DATE SIGNED 167 | | |
| 22c. PHYSICIAN NAME (Type | | DADDARI | 0 5413 C | EDAR LAN | e BETHESDI | | |
| 230. BURIAL, CREMATI REMOVAL (Specif | ON, 23b. DATE THEREO | | et Drave | 23d. LOCATION (City or To | wn) (County) (Stote) N Fairfart (Va | | |
| 24. FUNERAL OIRECT | | AODRESS | | BY REGISTRAR 256-RE | EGISTRADIS SIGNATURE | | |
| 1. 11. | 0 11 1/ | b 81 | 7 IAN | 3 1968 400 | cores years | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth. Page 4 may be retained by the hospital or attending physician. er deoth TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and complétely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carban payels. Page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours a

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CERTIFICATE | OF DEATH 17345 |
|---|---|
| 1. PLACE OF DEATH O. COUNTY ON ONT GOMERY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. b. COUNTY B. COUNTY |
| b. CITY OR TOWN (If autside carporate limits, write RURAL ond give neorest town) SINCER SPRING | c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Sweet Span B Wash. De 47.3 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street address) HOLY CROSS | d. STREET ADDRESS 3609-Nichols Anste ON A FARM? 2934 HEALGLAWN, RD, YES NO |
| 3. NAME OF DECEASED (Type or print) RALPH First Middle | Lost 4. DATE Manth Day Year OF DEATH 12 25 1967 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | B. DATE OF BIRTH 4-21-95 9. AGE (In years lost birthday) 2 yrs. FUNDER 1 YEAR IF UNDER 24 HRS. Manths Days Haurs Min. |
| 1Db. KIND OF BUSINESS OR during most of working life eyen if retired) 1Db. KIND OF BUSINESS OR INDUSTRY Auto Service | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME SawRenze J. Beinhart | 14. MOTHER'S MAIDEN NAME STELLA E. WATSON INFORMANT Address |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknawn) (If yes give war or dates af service) (16. SOCIAL SECURITY NO. 17. Results of service) | INFORMANT Address |
| IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave) (b) | Cuple Ceal |
| rise ta immediate cause (a), stoting the underlying cause last. DUE TO CC CC CC CC CC CC CC CC CC | g years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| OR CONTRIBUTING CAUSE OF DEATH U | (Enter noture of injury in Part I or Port II of item 1B.) |
| | ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.) 2Df. (City ar town) (County) (State) |
| 21. I certify that (I) (this haspital) attended the deceased fram saw the deceased alive an | to the date stated above |
| | D. ATTENDING MED. STAFF 226. DATE IGNED DIRECTOR PHYS. 12/26/6 |
| 22/ PHYSICIAN'S JOKN J. CURRY | 106 20 Georgen Ousely |
| 230. BURIAL (REMATION, PREMOVAL (Specify) 12-29-1967 Mt. Olivet | Cemettery Washington DC |
| Simmons Bros. 1661-Bood Hope Rd SE | DC 250. REC'D BY REGISTRAR 967 25b. REGISTRAR'S SCHATURE DEC 28 1967 |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be defached far use as the burial-transit permit. Then please remave carbor papers: Page-4 and 2 shauld be filed with the State Dept. at Health priar to burial, cremation, or remaval, and in any event, within 72 haurs after death. VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital ar attending physician.

THE REPORT OF THE PARTY OF THE " was 1 m stal STORY DESIGNATION 2111 112 1 6 4 modes 191 Contract to the to the contract of REMORT THE LA KANPY 4-21-95 1/2 X = 5 th 4 D.C. THE RESERVE OF THE PARTY. with a learnest grant to the to be the contract of the contract of the Simpons From 1 - Good Mops 14 Ja

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W PRESTON STREET BALTIMORE, MARYLAND 21201

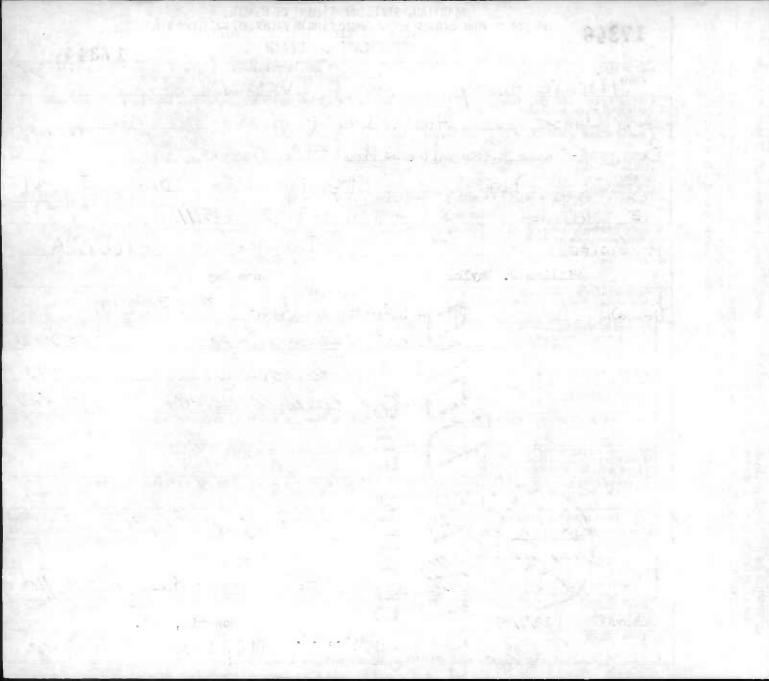
CERTIFICATE OF DEATH

| -0 | 7 | 2 | 1 | 8 | |
|----|---|-----|----|---|--|
| - | 6 | . 3 | 66 | 4 | |

| | | 1.1 | 344 |
|---|--|--|-----------------------|
| | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Reside | nce before odmission) |
| i | O. COUNTY MONTGOMERY MARYLAND | o. STATE IRGINIA b. COUNTY | 0 |
| - | b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 | c. CITY OR JOWN (If outside corporate limits, write RURAL and give | ve neorest town) |
| 7 | write RURAL and give nearest town) | Faranax | 22 - 2 |
| 4 | NAME OF HOSPITAL OR INSTITUTION (If not in bospital, give street oddress) | d. STREET ADDRESS | e. IS RESIDENCE |
| 4 | A STATE OF HOST HAL OK HISTHOTION (II HOT III) gospital, give sites outless) | 13.16.1) | ON A FARM? |
| L | DETHESDA- OKNER SPRING NURSING HONE | 13430 TICKET D. | YES NO |
| | NAME OF First Middle DECEASED | Lost 4. DATE Month | Doy Year |
| | (Type or print) | EKNER DEATH DEC | 5 1967 |
| | SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED | 8/ DATE OF BIRTH 9. AGE (In years IF UNDER Months) 1 - 9 - 4 2 | Doys Hours Min. |
| | TE WIDOWED \ DIVORCED | 7-9-82 B5 \$12 yrs. | Doys Hours Mill. |
| 0 | . USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | | ITIZEN OF WHAT |
| | ng most of working life, even if retired) INDUSTRY | ILLINOIS 7 | OUNTRA |
| | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| | William R. Taylor | Anna Day | |
| _ | | | |
| e | s no or unknown) (If we give wor or dates of service) | XTOO TONIES D | TILL HD. |
| إ | 14-6281A TAT | TIENT'S CHART CHEVY CHASE, I | ND. |
| | 18. CAUSE OF DEATH (Enter only one couse per line to (o), (b), one (c).) PART 1. DEATH WAS CAUSED BY: | INTERVAL BETWEEN | |
| | IMMEDIATE CAUSE (0) | elworkage | 15/1/12 |
| | 33/A DUE TO | 7 / | |
| l | Conditions, if ony, which gove) (b) Eselval (| 1 Lever eleveres | 3 485 |
| | rise to immediate couse (o), stoting the underlying couse | 2 1 1 2 - 1 | |
| ı | lost. (c) Chellerelleel | as remordenessis | 10 4 RS. |
| ı | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) | 19. WAS AUTOPSY |
| ١ | | | PERFORMED? YES NO |
| i | 20o. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or Port II of item 18.) | 1 10 0 10 0 |
| | OR CONTRIBUTING CAUSE OF DEATH | terror solution and injury in 1000 1 of 1000 1000 1000 | |
| I | (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INIURY Month Dov. Year 20d. INJURY OCCURRED 20e. PLA: | CE OF INJURY (Home, farm, 20f, (City or town) (Co | (5) |
| ı | | CE OF INJURY (Home, farm, tory, street, office bldg., etc.) | ounty) (Stote) |
| | p.m. 19 of work Of work | | |
| | 21. I certify that (I) (this hespital) attended the deceased fram_ | 3/67, 19, pto /2/5/6719. | , that (I) (we) la |
| | saw the deceased alive an 10/25/67 19 , and that | t death accurred at a UMM, fram causes and an t | the date stated abov |
| ľ | 220. SIGNATURE | | DATE SIGNED |
| | Hury Tesulbrio | ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. | |
| _ | 22c. PHYSICIAN'S | 22d. ADDRESS () / | HA m/ |
| | NAME (Type) HENRY C. SCRUGGS MI | 15413 (edas naue Del | werden me |
| | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | CREMATORY . 23d. LOCATION (City or Town) | (County) (Stote) |
| | Removal (Specify) 12/7/67 | Nokomis, Ill. | (5.5.5) |
| | | D. C. 250. RECID BY REGISTRAR 25b. REGISTRAR'S | SIGNATURE |
| | 1. 00 D. | 1200 DEC 1 1 1007 W/ | vley Judge |
| (| Joseph Lewer o Sons Vace Wiece | darrest part Ut & II 1001 | 10 |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and shauld be filed with the State Dept. at Health priar to burial, crematian, ar remaval, and in any event, within 12 hours after death. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in Downe funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers—Pages 1 And should be filed with the State Dept. of Health prior to burial, cremation, or remaval, and in any event, within 72 hour, after deat Page 4 may be retained by the hospital ar attending physician. VR A15 (4) 25M 1/67

| tem | 2 | see | Birth | Cert. | MARYLAND | STATE D | EPARTMEN | T OF HEALTH | | |
|-----|-----|--------------|-------|--------------|--------------|----------|-------------|--------------|----------|-------|
| | | | DIVI | SION OF VITA | L RECORDS, 3 | 01 W. PR | ESTON STREE | , BALTIMORE, | MARYLAND | 21201 |
| | 0 0 | - ATT - 10 - | | | | | | | | |

| 17347 CERTIFICATE | OF DEATH 173 | 46 |
|--|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence as STATE b. COUNTY OF THE COUNTY | before edmission) |
| b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If autside carparate limits, write RURAL and give | |
| write RURAL and give nearest town) BETHESDA (RURAL) 1 DAY | BEAMESDA/(BURAL)/ Leonar | dtown 18.2 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE |
| | | ON A FARM? |
| NAVAL HOSPITAL | NAVAL/HOZPIVAL Park Ave | |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Manth OF | Doy Year |
| (Type or print) ANDREZ MONTAG | RICE DEATH DECEMBER | 15 19 67 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | o. order | YEAR IF UNDER 24 HRS. Days Hours Min. |
| MALE NEG WIDOWED DIVORCED | 15 DEC 67 - yrs. | 1 |
| 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | | ZEN OF WHAT |
| during most of working life, even if retired) INDUSTRY | SAINT MARY'S md US | NTRY? |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 4 |
| ELMER M. RICE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT Address | |
| (Yes, na, ar unknown) (If yes give war or dates of service) | | |
| | BERTA MARTE RICE PARK AVE LEOI | |
| 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART 1. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (6) MASSIVE BILATERAL | AWELECTOSIS | |
| 160.5 DUE TO | | |
| Canditions, if any, which gove (b) PREMATURITY & IMMA | TURITY | |
| stating the underlying cause DUE TO | | |
| last. (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES X NO |
| GE OR CONTRIBUTING CAUSE OF DEATH | (Enter nature of injury in Part I or Part II of item 18.) | |
| | CE OF INJURY (Hame, farm, ory, street, affice bldg., etc.) (City ar town) (Cau | nty) (State) |
| 21. I certify that (I) (this haspital) attended the deceased fram_1 | 5 DEC , 19 67, to 15 DEC , 19 6 | 7 that (I) (we) last |
| saw the deceased alive an 15, DEC 19.67, and tha | t death accurred at 1110PM, fram causes and an th | e date stated abave. |
| 220. SIGNATURE ALL MA | D. ATTENDING MED. STAFF DIRECTOR PHYS. 16 1 | TE SIGNED DEC 1967 |
| 22c. PHYSICIAN'S NAME (Type) G.P. SWARTZ, IJ, MC, USN | NAVAL HOSPITAL, BETHESDA, N | D. |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | CREMATORY . 23d. LOCATION (City or Town) (| County) (Stote) |
| Burial Dec. 24, 1967 Bethesda Meth | odist Cemetry Leonardton | Momerland |
| 24. FUNERAL DIRECTOR ADDRESS | odist Cemetry Leonardtown 25g. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG | Maryland GNATURE |
| Mattingley Funeral Home , Leonardtown. | | |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17347

| HEALTH | DEPT. | 1. | | 2. USUAL RESIDENCE (Where deceosed lived if institution: Residence | before admission) |
|---|---------------------------------------|---------------|--|---|---|
| S 0 0 | of | | o. COUNTY MARYLAND MARYLAND | o. STATE DOWNTY SALE | of ame |
| 300 | Ē | | h CITY OR TOWN (If outside dornorate firsts I chength of STAY IN Ih | c. CITY OR TOWN of outside corporate limits, write RURAL and give | neorest town) |
| 8 | Ē | | write BURAL and give nearest town | Koa Khuillo | 1 15.11 |
| P C C | Deportment | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE |
| If is 1, orm | 2 | 7 | Jakerban | 12709- (=Len7/1/1/ Xa | ON A FARM? |
| hours after deoth. If Item 18. Give Poges 1, Office olong with form | e Star | 3. | NAME OF First Middle | Lost / 4. DATE Month | Doy Year |
| r de ive l | 112 | L | OFCEASED (Type or print) Mary Home 71 | CKOTTS DEATH LIGE | 24 1967 |
| afte 8. G | with | S. | | | YEAR IF UNDER 24 HRS Doys Hours Min. |
| m l | land 2 w er deoth. | 10 | DIVORCED DIV | 1/20ch 31,1932, 35yrs. | ZEN OF WHAT |
| | | du | ripg most of working life, even if retired) INDUSTRY | The skilling of long from the country (COUNTRY) | NIKY? |
| n 24 il in ner's | poges urs offe | 13 | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 0,0111 |
| e executed within 2 pending" in pencil i ef Medical Exominer | it. File pog 72 hours | | Jandsus Kild. | 240 | |
| in LEX | 72 F | | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INF | FORMANT Address | |
| ng" dica | permit. | (1 | es, no, or unknown) (If yes give wor or dotes of service) | | |
| exe endi | | F | 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) | 2 1 | INTERVAL BETWEEN |
| ٥: ١٠ | buriol-tronsit | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Noitiple | ngusies - Severe - | St and death |
| word the C | y e | | DUE TO | - Guto Accident - | |
| she w | buriol ony | | rise to immediate couse (a) | -GOTO A CERCIANT - | |
| ote g th | .= | | stoting the underlying couse DUE TO | | |
| rific rifin arde | o o o o | | DADT II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE | F TERMINAL DIFFACE CONDITION CIVIEN IN PART 1/1 | 19. WAS AUTOPSY |
| s certificate e, writing t forwarded | be used removol, | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE | : TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | PERFORMED? |
| Thi: icate | l be remo | IFICA | 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (En | nter noture of injury in Port I or Port II of item 1B.) | 113 110 12 |
| certif ould | les. should | | PRIMARY Or CONTRIBUTING CAUSE OF DEATH. | | |
| INE c | your files Poge 3 sh cremation, | MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 2 20e. PLACE | OF INJURY (Home, form, 20f. (City or town) (Coun | 17 |
| CAN e the | oge | 5 W | | y, street, office bldg., etc.) Dawson Ville_M. | oly Fraction to |
| ecut Pog | 5.00 | | 21. I certify that I took charge af the remoins described abave, held | | and in my apinio |
| CAI ex | ECTO! | 1 | death resulted fram: Natural causes , Accident , Suicide | | |
| ED ease irect | toine DIRE To b | | ACTUAL OP & P AD | CHIEF MEDICAL EXAMINER | |
| Y N | - L | | | M.D. ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| DEPUTY cessory, e funerol | may be FUNERAL | 2 | EXAMINER'S NAME (Type) | DEPUTY MEDICAL EXAMINER 12/24/6 Address (Street, city, town, or county) | / |
| DE DE | FUNE ealth | 23 | o. BURIAL CREMATION. 23b. DATE THEREOF. 23c. NAME OF CEMETERY OR CRI | | County) (Stote) |
| 5 = = | 2 ± | 2 | REMOVAL (Specify) 12/28/67 Morroconf | 2 11: 011 | nate und |
| VP A | 15ME (5) | 2 | 4. FUNERAL DIRECTOR Ernest C Gartner ADDRESS | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG | NATURE |
| | 1/67 | | 1. Mkeyan Conthurstore | MA DATE DEC 2 8 1961 | 1 0 |

TO THE REAL PROPERTY OF THE PR

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| 121 | | | CERTIFICATE | OF DEATH | 17 | 348 |
|------|---------------|--|--|--|----------------------------------|-------------------------------|
| deof | 1. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where dec | eosed lived, if institution: Re- | sidence before odmission) |
| | | o. COUNTY M | MARYLAND | o. STATE | b. COUNTY | |
| | - | b. CITY OR TOWN (If purside corporate lin | | c. CITY OR TOWN (If outside corp | orate limits write PUPAL and | aive negrest town |
| | | write RURAL and give nearest town) | 1680 | | ordie minis, wille KOKAL dit | give negress town/ |
| | | Wheaton | 100 days | wheaton | | /5-/ |
| 90 | Po | H. NAME OF HOSPITAL OR INSTITUTION (IF | not in hospitol, give street oddress) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| 10 | 4 | Oll Randolph Roac | 10 Wheaton | 3109 Veron | a prive | YES NO |
| | 3. | NAME OF Antionette | First Middle | Lost 4. DAT | E Month | Doy Year |
| | | (Type or print) | C Ro | adgers DEA | TH 12 | 29 1967 |
| | S. | SEX 6. COLOR OR RACE | 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH | | DER 1 YEAR IF UNDER 24 HR |
| | | Temale White | WIDOWED & DIVORCED | 10-XX-1889 | lost birthdoy) Mont | hs Doys Hours Min |
| | | USUAL OCCUPATION (Give kind of work do | | 11. BIRTHPLACE (County & Stote, or | foreign country) | 2. CITIZEN OF WHAT |
| | | ng most of working life, even if retired) | Own home | Wash h. | 0 | COUNTRY ? |
| | - | FATHER'S NAME | 0477 120770 | 14. MOTHER'S MAIDEN NAME | | |
| | Vi. | lson Robey WXX | THE KYL | BXXXXXXXX | Susan Barret | + |
| | 15. | WAS DECEASED EVER IN U.S. ARMED FORCE | S? 16. SOCIAL SECURITY NO. 17. | INFORMANT | | |
| | (Ye | s, no, or unknown) (If yes give wor or dote | e of convice V | s. Frances E. Ha | sion e | rona Drive |
| | H | MO | | a. Jaunicea (. Mu | men onwen | |
| | | 18. CAUSE OF DEATH (Enter only one PART I. DEATH WAS CAUSED BY: | 11.2 | | | ONSET AND DEATH |
| | | IMMEDIATE CAU | | | | Iwk |
| | | Conditions, if ony, which gove) | UE TO | 1 11 1 | | 1. A |
| | | rice to immediate couse (a) | (b) aneurysm | of con | ~ | 1001 |
| | | stoting the underlying cause | OE IO | 2 | 1 1 | 1100 |
| | | last. | (c) or me wase | croses of a | our | 17/13, |
| | NO | PART II. OTHER SIGNIFICANT CONDITIONS | CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION G | IVEN IN PART 1(o) | 19. WAS AUTOPSY PERFORMED? |
| - | CATI | Cerebral Vas | cular Acquent | rarkinson | 15m | YES NO |
| 2 | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or I | Port II of item 18.) | |
| | | (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| | MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. | | CE OF INJURY (Home, form, 20f | . (City or town) | (County) (Stote) |
| | ME | p.m. 1 | 9 While Not While of work | tory, street, office bldg., etc.) | | |
| | | 21. I certify that (1) (this h | aspital) attended the deceased fram | 9/12 1961 | to 12/29 | 19 6 7hat (I) (we) |
| | | saw the deceased alive an_ | 12/28 1967, and tha | t death occurred of 3 A | M, from causes and a | n the date stated obc |
| | | 22o. SIGNATURE | + 0 | | 228 | DATE SIGNED |
| | | Kaymond | 1. Benack M. | D. ATTENDING MED. DIRECTOR | STAFF PHYS. | 2/29/67 |
| T | | 22C. PHYSICIAN'S | 1-0 1 | 22d. ADDRESS | | 1 |
| - | 1 | NAME (Type) & Ay mor | id I. DenACK m | 10 4115 Colie D | RIVE, who | solan, md, |
| | 230 | . BURIAL, CREMATION, 23b. DATE | THEREOF 23c. NAME OF CEMETERY OR | CREMATORY 23d. | LOCATION (City or Town) | (County) (Stote) |
| | | REMOVAL (Specify) Dan. | 2. 1968 Rock Creek (| | ashinaton D | C |
| | 24 | FUNERAL DIRECTOR Shirmas | ADDRESS - | A. 250. REC'D BY REGI | STRAR 2Sb. REGISTRA | |
| | KU | wher E. Pumphreu | Inc. Silver Spring | Md DATAN 8 | 1968 10lian | May Indas |

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CFRT | | TE | O.E. | DEA | TILL |
|------|--------|----|------|------|------|
| LPKI | IPIL A | | V/F | 1754 | |

17350

| | | | | 1000 |
|--|--|--|--|-----------------------------------|
| 1. PLACE OF DEATH 0. COUNTY | | A STATE | Where deceosed lived, if institution b. COUNTY | |
| Montgomery | MARYLAND | Mary | land | Baltimore / |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest tawn) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If ou | tside corporote limits, write RURAL | ond give neorest town) |
| Gaithersburg | 5yrs. 5mo. | Balt | imore | 03.2 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hos | pitol, give street oddress) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| Asbury Methodist | Home | 9811 Hartf | ord Road | YES NO X |
| 3. NAME OF First | Middle | Lost | 4. DATE Month | Doy Year |
| OFCEASED (Type or print) Mrs. Mary | Alice Schneid | | OF DEATH De | A |
| S. SEX 6. COLOR OR RACE 7. MAR | | B. DATE OF BIRTH | D 071111 | F UNDER 1 YEAR IF UNDER 24 HRS. |
| | | lugust 25 18 | last battiav) A | Months Doγs Hours Min. |
| | Ob. KIND OF BUSINESS, OR | 11. BIRTHPLACE (County | & Stote, or foreign country) | 12. CITIZEN OF WHAT |
| during most of working life, even if retired | ANDUSTRY Home | Virgini | a | COUNTRY? U.S.A. |
| 13. FATHER'S NAME | 1,000 | 14. MOTHER'S MAIDEN I | | |
| George H. Shimp | | Iva N. | Montgomery | Tell Care |
| 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) | 16. SOCIAL SECURITY NO. 17. 213-56-74-96 T | Metholis | of Home Address | Records |
| 1B. CAUSE OF DEATH (Enter only one couse per li | | 4 | 0 A / | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | Ucule my | ocardia | enfactors | ONSET AND DEATH |
| 7201 DUE TO / | 2.1. | 1. 0 | 1/ | 2 10- |
| Conditions, if ony, which gove) (b) | coperioseles | one hea | it disease | d YKS. |
| rise to immediate couse (a), Stating the underlying couse | | | | |
| last. (c) | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUT | TING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CON | IDITION GIVEN IN PART 1(n) | 19. WAS AUTOPSY |
| NO I | | | | PERFORMED? YES NO |
| S 200. ACCIDENT WAS UNDERLYING □ 2 | Ob. DESCRIBE HOW INJURY OCCURRED. | (Enter nature of injury in | Port I or Port II of item 19) | I ICS [] NO [2] |
| OR CONTRIBUTING CAUSE OF DEATH | OU. DESCRIBE HOTE INDUKT OCCURRED. | Trues morore or ridory III | TOTA OF TOTA OF HEIR TO.) | |
| THE ETITIER, NOTIFY MEDICAL EXAMINER | 201 MILLIPY OCCUPATO | CF OF MILLIPY (II) | I not (C) | 16 |
| Hour o.m. | | CE OF INJURY (Home, form tory, street, office bldg., etc.) | | (County) (Stote) |
| ≥ p.m. 19 | ot work ot work | 1/1/ | | |
| 21. I certify that (I) (this hospital) | | 7/1/63.1 | 8 to /2/2/6 | _719, that (1) (we) las |
| | 28/1719, and tha | t death occurred of | 330HM, from couses an | d on the date stoted abave |
| 220. SIGNATURE | 1 | AFTENDING | MED. STAFF | 22b. DATE SIGNED |
| Heur | Crusto 1 | DAHYS.) LS | DIRECTOR PHYS. | 12/2/67 |
| 22c. PHYSICIAN'S NAME (Type) | 00 | 22d-ADDRESS | | |
| NAME (Type) Henry C. Scru | ggs, M.D. | | | |
| 230. SURIAL, CREMATION., 23b. DATE THEREOF | 234. NAME OF CEMETERY OR | CREMATORY | 23d. LOCATION (City or Foun) | (County) (Stote) |
| REMOVAL Specify (12-5-67 | PAR Kula | 10 | BALLO | MX |
| 24. FUNERAL DIRECTOR | ADDRESS | | | JRAR'S SIGNATURE |
| L' & FUANDS Soul 9 | 802 Novetokes Ki | DATEDE | C 5 1967 400 | world judge |
| - LU L VITIYO VON D | 00 × / 100 11 11 11 | DAIDL | 0 ,, | // (/ |

IO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. Poge 4 moy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in director, page 3 should be detoched for use as the burial-transit permit. Then please remove corbon papers.

Ent grant was consulting a material and the contract of the co TIJS B oreconde Las weomon temis deithereburg byrs. Sac. Baltimore hape brotten 1180 most Jaibo del Troden drs. Err. Lice Bohneider August 28 1890 Marsh z dina elemen cial vil . . . wanostroie W svi George il. Bring 215-26-71.96 2 1 1 10 Key of 1 1 1 1 Key Manay U. Mortega, U.

MARYLAND STATE DEPARTMENT OF HEALTH

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17351 CERTIFICATE OF DEATH

> MARYLAND LENGTH OF STAY IN 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after deoth. Page 4 may be retained by the hospital or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral.

PLACE OF DEATH

CITY OR TOWN (If autside corporate limits,

VR 20

| S. E. | write RURAL and give nearest town) 14 5 mo /3 de District of Columbia. 47-3 | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
| hours hours | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? | | | | | | | | |
| 01 711 | Randolph Hills Nursing Nome 3051 Idaho Ave. NW. YES 10 NO | | | | | | | | |
| with | 3. NAME OF First Middle Last 4. DATE Manth Day Year | | | | | | | | |
| arb t, \ | DECEASED (Type or print) Eleanor F. Schnoor DEATH Dec 20 1967 | | | | | | | | |
| e c | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 11 8. DATE OF BIRTH 9. AGE (IN years 17 UNDER 1 TEAK 17 UNDER 24 HKS. | | | | | | | | |
| please remove I, and in any ev | Female white WIDOWED DIVORCED 13/6/1887 BO yrs. Manths Days Haurs Min. | | | | | | | | |
| n a | 10a. USUAL OCCUPATION (Give kind of work dane libb. KIND OF BUSINESS OR liberation of working life even if retired) 10b. KIND OF BUSINESS OR liberation of working life even if retired library? | | | | | | | | |
| ase | during most of working life, even if retired) INDUSTRY Rochester N.Y. COUNTRY? | | | | | | | | |
| o', o | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | | | | | | | | |
| Then | Frank F. Warth Mary T. Weigel | | | | | | | | |
| rem | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT / Address | | | | | | | | |
| the burial-tronsit permit. Then please remove carbon pop or to burial, cremation, or removol, and in any event, within | (Yes, no, or unknown) (If yes give war or dates of service) 114 143748 RANDOLPH HILLS NURSING HOME'S RECORDS | | | | | | | | |
| per | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN | | | | | | | | |
| ma | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Care brat Vascular Accident minutes | | | | | | | | |
| cre | DUE TO | | | | | | | | |
| -loi loi | (anditions, if any, which gave) (b) (PRP byal ARTER 108-1880SIS Brown TA | | | | | | | | |
| | rise to immediate cause (a), Stating the underlying cause DUE TO | | | | | | | | |
| r to | last. (c) | | | | | | | | |
| as prio | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY | | | | | | | | |
| should be detoched for use as the ith the Stote Dept. af Health prior to | PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTION OF CONTRIBUTIO | | | | | | | | |
| Hed | 20a. ACCIDENT WAS UNDERLYING \(\square\) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) | | | | | | | | |
| of d | © OR CONTRIBUTING □ CAUSE OF DEATH | | | | | | | | |
| oche ept. | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) | | | | | | | | |
| det de D | Haur a.m. While Nat While factory, street, affice bldg., etc.) | | | | | | | | |
| Stot | p.m. 19 at wark L at wark L 21. I certify that (I) (this hospital) attended the deceased from 7/7 , 1966, to 2/20, 1967, that (I) (we) la | | | | | | | | |
| | sow the deceosed olive an 12/20 1967, and that death occurred at A.M., from couses and on the date stated above | | | | | | | | |
| th | 220. SIGNATURE 22b. DATE SIGNED | | | | | | | | |
| e × × | Raymond T. Benack M.D. ATTENDING MED. STAFF DIRECTOR DIRE | | | | | | | | |
| file | 22c PHYSICIAN'S 22d. ADDRESS | | | | | | | | |
| Pe P | NAME (Type) RAYMOND 1. BENACK MD 4/15 Colle DRIVE, Wheaton, md | | | | | | | | |
| director, page 3 should should be filed with the | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) | | | | | | | | |
| sh di | Burial Dec. 22, 1967 Holy Sepulchre Cem. Rochester, New York. | | | | | | | | |
| 115 (4) | 24 JUNEAL DIRECTOR 250. REGISTRAR'S SIGNATURE | | | | | | | | |
| A15 (4) A 1/66 | H. Low. DE VOL 2222 Wis. Ave. N. W. Wash. DATE JAN 2 1968 Charles Judges | | | | | | | | |
| | | | | | | | | | |

A STANLES OF THE STANLES OF THE STANLES

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | 7.7 | 3 1 0 8 | |
|-----------------|--|--|-------------------|-----------------------------|---------|---|------------------|------------------------------|--------------------|--------------|---------------------------|
| | PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (V | Where deceose | ed lived, if institu | | ce before o | dmission) |
| | Montgome | ry | | MARYL | AND | Maryland | | 0. (0) | JINI A | 172 | |
| | | If outside corporate limit d give nearest town) | S, | c. LENGTH OF STAY IN | 16 | c. CITY OR TOWN (If ou | tside corporot | e limits, write Rl | URAL ond give | e nearest to | own) |
| | Takoma F | | | 1 day | | Anapolis, | Junct | ion | (Anapo | | |
| | d. NAME OF HOSPIT | AL OR INSTITUTION (If n | ot in hospitol, g | give street oddress) | | d. STREET ADDRESS | | | | e. I | S RESIDENCE ON A FARM? |
| | Washingt | on Sanitar | ium and | Hospital | | Box 46 | | | | YES | |
| | NAME OF DECEASED | Fi | rst | Middle | | Lost | 4. DATE OF | Mor | nth | Doy | Year |
| | (Type or print) | Hugo | | Herman | | Schwarz | DEATH | Decemb | | | 19 67 |
| S. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | | B. DATE OF BIRTH | 9. | AGE (In years last birthday) | IF UNDER Months | | Hours Min. |
| | Male | White | WIDOWED | DIVORCED | | 10-26-98 | | -/ | | | |
| | USUAL OCCUPATION ing most of working | N (Give kind of work done life, even if retired) | | ND OF BUSINESS OR DUSTRY | | 11. BIRTHPLACE (County | & Stote, or fore | eign country) | (0 | TIZEN OF W | |
| | | | Got | vernment | | Germany | | | A | meric | a |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN N | | | | | |
| 1 | Car | L Schwarz | 1.1 | todiii erailaiyu ua | 1 . 7 . | Teresa | Knitzi | | | | |
| (Ye | es, no, or unknown) | R IN U.S. ARMED FORCES? (If yes give wor or dotes | of service) | SOCIAL SECURITY NO. | | NFORMANT | 9175 | Add | ress | | |
| | yes-IVO | German Nav | У | | | Patient's ch | art | 1 | | | |
| | | EATH (Enter only one con TH WAS CAUSED BY: | use per line for | (o), (b), ond (c), | 111. | | / | · hat | 1 | | AND DEATH |
| | 4201 | IMMEDIATE CAUSE | '' | rain, | Mu | waima | 1 pr | The Col | | a | upo. |
| | Conditions, if ony | DUE | / , | 1 1 0 : :00 / | . 1 | Atic h | inst | Moin | 200 | 140 | ain |
| | nse to immediat | te couse (o), (| (b) | 1 Marior C | M | 7000 | TOUT ! | vera | u | 1 | 0007 |
| | stoting the unde | rlying couse | | | | | | | | | |
| | | IGNIFICANT CONDITIONS | (c) | O DEATH BUT NOT BELA | TED TO | THE TERMINAL DISEASE CON | IDITION GIVE | IN PART 1(a) | | 19. W/ | AS AUTOPSY |
| NO | C//. | mue / | D 404 (| 1. Tab | 1 | ullun er | | THE PART TO | | PEI YES | RFORMED? |
| FICA | 20o. ACCIDENT WA | | 20h DF | SCRIRE HOW INITIRY OC | | (Enter noture of injury in | | II of item 1R.) | | 11.3 | |
| L CERTIFICATION | OR CONTRIBUTING | CAUSE OF DEATH MEDICAL EXAMINER) | 200. 00 | SCRIBE HOW HOOK! OCC | LOKKEO. | Enjoi notoro ot injory in | 1011 1 01 1011 | 11 01 110111 12.7 | | | |
| MEDICAL | 20c. TIME OF INJ | URY Manth, Doy, Year | 20d. IN While | | | E OF INJURY (Home, form ory, street, office bldg., etc.) | | (City or town) | (Co | unty) | (Stote) |
| × | р. | 10 | ot work | | 1001 | ory, shoot, office blag., ofc.) | 1 | 2 | | 17 | |
| | | fy that (I) (this has | | | | , 1 | 961, to | MC: 2 | 194 | /, that | |
| | | eceased alive an_ | ACCI | 194, 01 | nd that | death accurred at | 13, bw | , tram causes | - | | stated abave |
| | 22o. SIGNATURE | (/// | Hall | 2/6 | M.E | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | | ATE SIGNED | 15, 1967 |
| | 22c. PHYSICIAN'S NAME (Type | | m W: | DANISH | + | 22d. ADDRESS | SPRI | INS 5 | 7. | 5.5. | Md. |
| 230 | D. BURIAL, CREMATIO | | EREOF | 23c. NAME OF CEMET | ERY OR | CREMATORY | | CATION (City or T | own) | (County) | (Stote) |
| 1 | REMOVAL (Specific | m 1/1/ | 167 | #TLINCO | ZN | CREMATORY | | | IRG | 2018 | 11/1 |
| 24 | FUMERAL DIRECTO | Daker : | 550 WA | ADDRESS CIL BUILD I | 10+1 | MI DATE DE | C 2 7 | 1967 2Sb. 1 | REGISTRAR'S S | SIGNATURE | edge. |
| | - | | -VI | HOVELL | Eh | 11/4 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event, within 72 have settled earth. VR A15 (4) 25M 1/67

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> CHEST EXTENSES CREATED The things with a state of the state of the

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17353

lost

| de of the state of | 1. | PLACE OF DEATH o. COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence o. STATE Washington, D.C. COUNTY | re before odmission) |
|--|-----------------|--|--|--|
| in 24 hours after filled in by the fune papers. Pages 1 a thin 72 hours offy decided the papers. | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Bethesda 34 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give Washington, D.C. | neorest town) |
| in b | - | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENC |
| filled in paper thin 72 | T | he Clinical Center, Bethesda, Maryland | 1600 16th Street, N.W. | ON A FARM: YES NO |
| pletely fi carbon ent, with | 3. | NAME OF First Middle DECEASED (Type or print) Joseph (NMN) | Scrippens 4. DATE Month OF DEATH December | Doy Year 23 19 67 |
| ne executed with ond completely remove carbon in ony event, wii | | | B. DATE OF BIRTH 9. AGE (In years last birthdoy) 19 March 1925 42 yrs. | Doys Hours N |
| that the death certificate be executed within 24 hours an. by the ottending physician and completely filled in by transit permit. Then please remove carbon papers. Pacrematian, ar removal, and in any event, within 72 hours | dy P | o. USUAL OCCUPATION (Give kind of work done ring most of working life, even if retired) hoto Lithographer Lithographic Co. | 11. BIRTHPLACE (County & Stote, or foreign country) Pennsylvania 12. CIT CQL | UNITRY? USA |
| hysi n pla val, | 13 | . FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| The P | 16 | Michael Scrippens | Anna Kohan | |
| ottending permit. The | (X | Yes 1943-45 199-14-3960 Th | INFORMANT The Medical Records 1965 are Clinical Center, Bethesda, Ma | aryla nd |
| thot the d an. by the ott ronsit pen crematian, | | 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Myocardial Infarc | tion | ONSET AND DEATH |
| quires 1 ohysicia igned 1 igned 1 ourial-tr | | Conditions, if ony, which gove rise to immediate cause (o), (b) Aortic Insufficient | ncy | 12 years |
| law rec | | stoting the underlying couse DUE TO Rheumatic Valve D: | | 20 years |
| or offer te hos use or alth pr | CATION | 8 days following open heart surgery for the su | the TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) or aortic valve replacement. | 19. WAS AUTOPSY PERFORMED? YES XX NO |
| PHYSICIAN e hospital nis certifico tached for Dept. af He | L CERTIFICATION | 200. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (IF EITHER, NOTIFY MEDICAL EXAMINER) | . (Enter noture of injury in Port I or Port II of item 1B.) | |
| the hor this detact | MEDICAL | | ACE OF INJURY (Home, form, ctory, street, office bldg., etc.) | unty) (Stote |
| rrending by OR: After ON: After Ould be ould b | | 21. I certify that (X (this haspital) attended the deceosed from—saw the deceased alive an 23 December 1967, and that | 19 November 19 67, to 23 Dec. , 19 6 at death accurred at 10:1%, fram causes ond on the | 27, that (X (we) ne dote stated ab |
| A # II # II | F | 220. SIGNATURE Cic H. Johnson M. | .D. PHYS. DIRECTOR PHYS. 23 I | ntesigned 1967 December |
| HOSPITAL OR ge 4 moy be FUNERAL DIR rector, poge 3 hould be filed | | 22c. PHYSICIAN'S NAME (Type) Eric H. Johnson, MD | 22d ADDRESSThe Clinical Center, I Institutes of Health, Bethes | |
| TO HOSPITAL OR A Page 4 moy be re TO FUNERAL DIREC director, page 3 should be filed w | 23 | o. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR St. Mary's | | (County) (Stote) |
| VR A15 (4) 25M 1/67 | | 4. FUNERAL DIRECTOR ADDRESS | 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SI | GNATURE |
| 25M 1/67 | | Robert A. Pumphrey, Bethesda, Mar | ryland DATE DEC 29 1967 Police | relag Jacobuse |

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| BAEDICAL | EVASSINIEDIC | CEDTIFICATE | OF | DEATH |
|----------|-------------------|-------------|-----|-------|
| MILDICAL | FXAMINFR'S | CERTIFICATE | UH- | UFAIR |

| FOK 2 | AIL | | | MEDICAL EXAMINER 3 | CERTIFICATE OF DEATH | 17354 |
|---|---------------------------------------|---------------|---|--|---|--|
| EALTH | DEPT | 1. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceosed lived, if in | stitution: Residence before admission) |
| 0 0 | IAI | | o. COUNTY | AA A DVI AAID | o. STATE b. | MONTGOMERY |
| 3 4 | | | MONTGOMERY D. CITY OR TOWN (If outside corporate limits.) | MARYLAND c. LENGTH OF STAY IN 1b | C. CITY OR TOWN (If outside corporate limits, wri | MIONT GOMERY |
| y del | a me | | write RURAL and give nearest town) | | | ie kukat dilu give nediesi luwii) |
| P. O. | P | | TAKOMA PARK | D.O.A. | TAKOMA PARK | 15-1 |
| E | Depor | | H. NAME OF HOSPITAL OR INSTITUTION (If not in | - / | d. STREET ADDRESS | e IS RESIDENCE ON A FARM? |
| es far | 0 19 | | WASHINGTON S | AN. & HOSP. | 717 BAYFIELD | STREET YES NO X |
| hours after death. If a Item 18. Give Pages 1, Office alang with farm | with the State | | NAME OF First | Middle | Lost 4 DATE | Month Doy Year |
| × ve d | the | | Type or print) GEORGE | BEALE SEE | K DEATH 12 | -4 1967 |
| fter Gi | £ | S. | SEX 6. COLOR OR RACE 7. | | 8. DATE OF BIRTH 9. AGE (In ye | ors IF UNDER 1 YEAR IF UNDER 24 HRS |
| s al | 2 × † | | MALE WHITE V | VIDOWED DIVORCED | 11-9-97 last birthd | py) Months Doys Hours Min. |
| hour: Item Office | pages land2 v urs after death | 100 | USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (Stote or foreign country) | 12. CITIZEN OF WHAT |
| | 10 | duri | ng most of working life, even if retired) | INDUSTRY | Magyiaila | C. S. A. |
| l in er's | ges | 13 | FATHER'S NAME | | MARYLAND 14. MOTHER'S MAIDEN NAME | U. 3-14- |
| within pencil xamine | | | 0 - | | T | 6 |
| d wi | LL | 10 | WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. | INFORMANT | A 1 1 |
| i ir | | (Ye | s, no, grunknown) (If yes give wor or dotes of ser | A Committee of the Comm | | Address |
| executed within 2 nding" in pencil ii Medical Examiner | permit. within 72 | | No | 579-22-8604 M | AY SEEK - NIECE | |
| e execut pending" ef Medico | | | CAUSE OF DEATH (Enter only one couse p PART I. DEATH WAS CAUSED BY: | er line for (o), (b), and (c) | 0 00" | INTERVAL BETWEEN ONSET AND DEATH |
| -0 : -= | ans | | IMMEDIATE CAUSE (o) _ | acute coros | cary Insuffice | ciency |
| ward the C | 3l-↑r y e\ | | T J O I DUE TO | 0.4 · 0 | De 11 /4 | 10 - 1 |
| _ | burial-transit | | Conditions, if ony, which gove rise to immediate couse (o), (b) | Weresch | rollic Heart | Visadse |
| d to | = | | stoting the underlying couse DUE TO | | | |
| fice | and and | | last. (c) | | | |
| s certificate s e, writing the farwarded ta | used aval, | × | PART II. OTHER SIGNIFICANT CONDITIONS CONTE | RIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 | (o) 19. WAS AUTOPSY PERFORMED? |
| | be used remaval, | CERTIFICATION | | | | YES NO |
| Thi icat be | d b | TIFIC | 20o. EXTERNAL CAUSE WAS | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port 1 or Port II of item 1 | 8.) |
| certif auld | should an, ar i | | PRIMARY Or CONTRIBUTING CAUSE OF DEATH. | The state of the s | | |
| MINER the cer 4 shau | yaur riles Page 3 sh crematian, | MEDICAL | 20c. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURRED 20e. PLA | ACE OF INJURY (Home, form, 20f. (City or tow | vn) (County) (State) |
| AH TH | age | MED | Hour o.m. p.m. | While Not While of work | tory, street, office bldg., etc.) | |
| EX. cute age | | | 21. I certify that I toak charge at | | eld an Autapsy , Inspection X. | Inquiry , and in my opinio |
| AL Exe | ECTOR: burial, | | death resulted frame, Natural co | | | |
| Se se seda | Pui Pui | | dedin resolved fiding National Co | Joses Accessin, Suit | cide, Hamicide, Undetermine | ed monner |
| ME lea dire | 5 Kg | | ACTUAL TO Oller | K Conh | ACCICTANT MEDICAL EVALUATED | 22. DATE SIGNED |
| T de la | RAI prior | | SIGNATURE / CLEAREN | Jergs, | M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER | 2 |
| Cessary, e funeral | FUNERAL alth pric | | EXAMINER'S RAME (Type) BEIDEN | R. REDD M. | D Address Stock Aty Country or country) | DEC. 41967 |
| 0 0 0 | | 230 | BURIAL, CREMATION, 23b. DATE THEREO | F 23c. NAME OF CEMETERY OR | | or Town) (County) (State) |
| 5 mm | 2=() | | REMOVAL (Specify) | | | |
| | M | - 24 | Burial Dec 7 | ADDRESS | 250 REC'D BY REGISTRAR 1 25 | |
| | 5ME (5) | 28 | AKNER FUMPHICEY | 8434 Georgia Avenu | DEC 1-1 1967 | Milarley Judge |

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Day

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12. CITIZEN OF WHAT

CQUNTRY?

e. IS RESIDENCE

ON A FARM?

Year

196

Hours

INTERVAL BETWEEN

CONSET AND DEATH

ND -

19. WAS AUTOPSY PERFORMED? YES X NO (County) (State) and in my opinion 22. DATE SIGNED Maryland REGISTRAR'S SIGNATURE

All Andrews and the second TO SEE MAN TO MAKE SEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 moy be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician ond completely filled in by the director, page 3 should be detached for use as the burial-tronsit permit. Then please remove carbon papers. Pagg should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 7 bours.

MARYLAND STATE DEPARTMENT OF HEALTH F VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CERTIFICAT | TE OF DEATH 17356 |
|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE MARYLAND b. (OUNTY MONT GOMERY) |
| b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) OLNEY C. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town) ELLICOTT CITY / 3 - 3- |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL | d. STREET ADDRESS RT. 2 e. IS RESIDENCE ON A FARM? YES NO X |
| 3. NAME OF First Middle DECEASED (Type or print) VIOLA RACHEL | SELBY 4. DATE Month Doy Year OF DEATH DECEMBER 2 19 67 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) 6-16-01 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Doys Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, ar foreign country) 12. CITIZEN OF WHAT COUNTRY? WARYLAND U.S.A. |
| 13. FATHER'S NAME ZETTA EASTON | 14. MOTHER'S MAIDEN NAME MINNIE MUSGROVE |
| (Yes no or unknown) (If yes give wor or dotes of service) | 7. INFORMANT Address EDICAL RECORDS MONT. GEN. HOSP. OLNEY MD. |
| 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gove rise to immediate couse (o), stoting the underlying couse lost. DUE TO (c) ANCREATI | TIS NEOROTIC 8-12 LOKS |
| 200. ACCIDENT WAS UNDERLYING COURRED OR CONTRIBUTING CAUSE OF DEATH OF EITHER NOTIFY MEDICAL EXAMINER) | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) 19. WAS AUTOPSY PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) 19. WAS AUTOPSY PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) 19. WAS AUTOPSY PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) 19. WAS AUTOPSY PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) 19. WAS AUTOPSY PERFORMED? YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO On the Terminal Disease condition given in Part 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) YES NO YES NO |
| 20c. TIME OF INJURY Month, Day, Yeor Hour o.m. 19 While Not While of wark 21 certify that (1) (this haspital) attended the deceased fram. 1967, and the deceased drive an 1967, and the deceased of the deceas | PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) PLACE OF INJURY (Home, form, form, foctory, street, office bldg., etc.) PLACE OF INJURY (Home, form, form, foctory) (Stote) (County) (Stote) (Stote) ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 22b. DATE SIGNED DIRECTOR PHYS. 22d. ADDRESS |
| 230. BURIAL (REMATION, REMOVAL (Specify) 12-5-67 GR 13 5 T LA 24. FUNERAL DIRECTOR ADDRESS HIS INDO CEDAR - Shock Fig. 12 5 5 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |

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heurs after death.

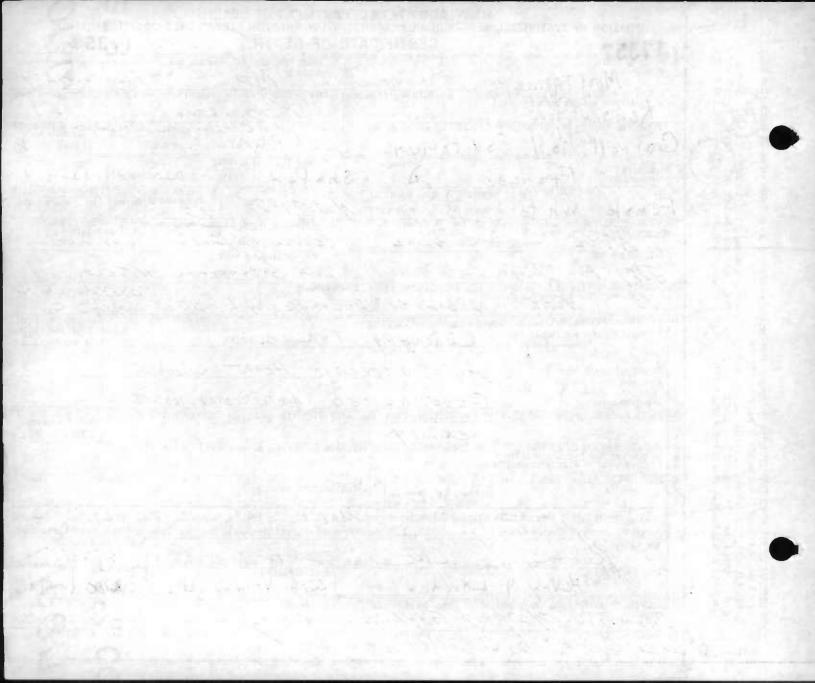
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within V2 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| | | O I |
|---|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY A | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Res | sidence before admission) |
| Man Tamery MARYLAND | a. STATE MD b. COUNTY ON. | TLOMERY |
| b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL a | and give nearest town) |
| Nensing ton | KENSINGTON, | 15,1 |
| d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) | 1.0 | ON A FARM? |
| COPPOIL LOUIS JONITORIUM. | 16231 (ARROLL VLACE | YES NO. |
| 3. NAME OF DECEASED (Type or print) FYS NCES | Shafe W. DATE Month OF DEATH DECCUBER | Day Year 2 1967 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | B. DATE OF BIRTH 9. AGE (In years IFUNDER 1 | YEAR IF UNDER 24 HRS. |
| Female White WIDOWED TO DIVORCED TO | Nov. 7,1874 Past birthday) Months 1 | Days Hours Min. |
| 10a. USUAL OCCUPATION (GIVE kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CIT | IZEN OF WHAT |
| Nove Nove | CLEVERAND COHTÓ ZA | J. A. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| JAG P. DAWLEY | LVA 6-155ELA CANTAES | P |
| (Yes, no, or unkown) (If yes give war or dates of service) | INFORMANT Address 5454 | Mother RD |
| NO NOWE 286-29-68380- | -CULATENRY L. SHATER- WASI | 4.D.C. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | T. D D | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY | THROM BOSIS | 15 MINUTES |
| DUE TO DUE TO | - 1/ | |
| gave rise to immediate | STIE HEART DISEASE | |
| cause (a), stating the DUE TO Underlying cause last, | D ARTERIOSCLEROSIS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | 71 | 19. WAS AUTOPSY |
| SEWILITY | | PERFORMED? |
| L | RRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU GOR CONTRIBUTING CAUSE OF DEATH G (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE | CE OF INJURY (Home, farm, 20f. (City or town) (Cour | ity) (State) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAC factor p.m. 19 While at work at work | ry, street, office bldg., etc.) | |
| 21. I certify that (I) (this hospital) attended the deceased from A | 144 1 , 1967 to DEC. 22, 196 | 2, that (I) (we) last |
| saw the deceased alive on DEC . 22 1967, and that | death occurred at (0:40M, from the causes and on th | e date stated above. |
| 22a. SIGNATURE | ATTENDING MED. STAFF 22b. DA | TE SIGNED |
| 22c. PHYSICIAN'S M.D. | | 12/6/ |
| NAME (Type) HENRY M. LOWGEN | 5206 NOHWAY DE, KENNY | and, Md |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | | nty) (State) |
| CREMATION JUST TORTHINEOU | en (REMARKY COLMER MANUER | TROSS CO, MD. |
| 24. FUNERAL DIRECTOR ADDRESS ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S | SIGNATURE |
| 10 100 (-111110 E1E) 00 -00 13111/06 1010 | DATE DEC 29 1901 | 00 |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CEDI | TIE | ICA | TE | OE | DEA1 | L |
|------|-----|-----|------|----|------|---|
| CEN | ш | IVA | NIE. | UL | DEAL | ш |

| | | CERTIFICATE | OF DEATH | | 17358 |
|-----------------------|--|--|--|---------------------------------|-------------------------------|
| 1. | PLACE OF DEATH o. COUNTY | MADVIAND | O. STATE PRINTING | countra b. COUN | 111 |
| - | b. CITY OR TOWN (If outside opporate limits) | MARYLAND c. LENGTH OF STAY IN 1b | CITY OR TOWN US OF | | KARKKAKKAKARA |
| | write RURAL and give nearest town) | 48dAUS | SYLVEY Y | de corporote limits, write RUR | Connellsville 3 |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in the | pospitol, give street oddress) | d. STREET ADDRESS Sy | campre Stree | |
| 2 | NAME OF First | Middle | 40000 BOXXXX | | YES NO |
| 3. | DECEASED | 1 81 / | 1 | DATE Mont | |
| - | (Type or print) ARA SEX 6. COLOR OR RACE 7. A | | TZER | DEATH Dec | |
| 3. | - / | | . DATE OF BIRTH | 9. AGE (In years lost birthdoy) | Months Doys Hours Min. |
| | Child Will C | IDOWED DIVORCED | 10-5-95 | 72 yrs. | |
| 10c | o. USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & St | ote, or foreign country) | 12. CITIZEN OF WHAT |
| 001 | Housewife | Own Home | Pennsylva | nia | EQUINTRY? A. |
| 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAM | 1E | |
| L | Issac Morgan | | Ida May Do | | |
| (Ye | WAS DECEASED EVER IN U.S. ARMED FORCES? es, no or unknown} {(If yes give wor or dotes of serv | | FORMANT. John E. Gr. | ubb 51 Winha | all Way |
| | 18. CAUSE OF DEATH (Enter only one couse pe | | | enwer of | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: | CEREBRAL ARTER | IAL SCLERO | SIS | ONSET AND DEATH |
| | 334 X IMMEDIATE CAUSE (o) | | | | |
| | Conditions if any which gave a | | | | |
| | rise to immediate couse (o), | | | | |
| | Storing the onderlying couse | | | | |
| | (4) | IDUATING TO DESTU DIT NOT SELECTED TO THE | IF TERMINAL DISCASE CONDIT | TOUR OFFICE OF THE | 10 INAC AUTODOV |
| CATION | PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRI</u> | BUTING TO DEATH BUT NOT RELATED TO TH | TE TERMINAL DISEASE CONVIT | ION GIVEN IN PART I(0) | 19. WAS AUTOPSY PERFORMED? |
| MEDICAL CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (E | Enter noture of injury in Port | I or Port II of item 18.} | |
| MEDICA | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 | | E OF INJURY (Home, form, ry, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| | 21. I certify that (1) this hospital | ottended the deceased from | Oct 19, 196 | | |
| | | Dec 6 1967, and that | death occurred at23 | M, from causes of | and on the dote stated obove. |
| | 220. SIGNATURE Soualian Me | VIlle aug M.D. | ATTENDING MEI | D. STAFF DECTOR PHYS. | 22b. DATE SIGNED DEC-6-67 |
| 1 | 22c. AHYSIOLAN'S | L. Williams- | 22d. ADDRESS POLS | live Dr. | Silver Spring |
| 230 | BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify). | 23c. NAME OF CEMETERY OR CE | REMATORY | 23d. LOCATION (City or Tov | wn) (County) (Stote) |
| 7 | rana-burial Dec. 8m 1 | 1967 Greenridge M rten8434 MP Sorgia Av | emorial Park | | GISTRAR'S SIGNATURE |
| W | | 2. Silver Spring. 1 | | | Milanles Jusce. |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon pagers. Pashauld be filed with the State Dept. of Health priar to burial, cremation, or remaval, and in any event, within 72 hours Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67

THE PARTY OF THE P B-JBYi de la companya de l Dec 67 Oct 19 267 Dec 67 0 Sonalisan Merselle anne-[3-2-000] A Tonathon M. Williams - 808 Pershing Dr. Slive price depend of the control The state of the s

Items 18&21 Film 396 12-2MARYLAND STATE DEPARTMENT OF HEALTH

| 1/359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before odopsis o. STATE Maryland b. COUNTY | ion) | | | |
|--|-----------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adaption of the state of | ion) | | | |
| | con. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town), Md. 7Days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | - 2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital d. STREET ADDRESS 4207 East WestHighway ves | IDENCE FARM? NO | | | |
| DECEASED (Type or print) Ralph J. Sheffer DEATH 12 6 19 | ear 67 | | | |
| male White WIDOWED DIVORCED 6/12/90 lost birthday) Months Days Hours | Min. | | | |
| 10b. KIND OF BUSINESS OR during most all working life, even if retired) C. P. A. 10b. KIND OF BUSINESS OR SINDUSTRY Self employed 11. BIRTHPLACE (State or loreign country) Wisconsin 12. CITIZEN OF WHAT COUNTRY A | | | | |
| 13. FATHER'S NAME Eddy Sheffer 14. MOTHER'S MAIDEN NAME Myrtie Maxon | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 577-40-6850 Charlotte M. Sheffer Hyattsville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) OUE TO Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last. OUE TO (c) | DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AU PERFOR YES | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY ar CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II al item 18.) 20c. TIME OF INJURY Manth, Doy, Year Haur o.m. 20d. INJURY OCCURRED VALUE OF INJURY (Hame, farm, foctory, street, allice bldg., etc.) (Caunty) | | | | |
| 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, foctory, street, allice bldg., etc.) P.m. 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, foctory, street, allice bldg., etc.) | (State) | | | |
| SIGNATURE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) BELDEN LEAP M. Daddies Street Str | E SIGNED | | | |
| Burial Dec 9, 1967 Ft Lincoln Cemetery Colmar Manor Pro Geo Md | (State) | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. 250. REC'D BY REGISTRAR 250. REGISTRAR'S SIGNATURE DATE DEC 11 1967 | ge. | | | |

VR A15ME 6M 1/67

follow. THOURSE alless appropriate views viewalle Loly Cross housical - 1207 East Self- She Dov on Tight . A .4.0 The commence of the commence o The Bearing of The Agency Contaction . Velocity The Same of the Company of the contract of the A STATE OF THE PROPERTY OF THE PROPERTY OF THE PARTY OF T

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CERTIFICATE | E OF DEATH | 360 |
|--|---|----------------------------------|
| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence | ce before odmission) |
| a. COUNTY MONTgomen MARYLAND | o. STATE DOOD b. COUNTY M | mtome |
| b. CITY OR TOWN (If outside corporate limits, | c. CITY OR TOWN (If outside corporate limits, write RURAL and give | neorest town) |
| write RURAL and give nearest town) VEARS | Kensing ten | 16 |
| d. NAME OF HOSPITAL OK INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE |
| - 3907 WARNER ST. | 3907 Warner St. | ON A FARM? |
| 3. NAME OF First Middle | Lost / 4. DATE Month | Doy Year |
| OFCEASED (Type or print) HOIPM | heldon OF Dec. | 30 1967 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER Months) Months | Days Hours Min. |
| WIDOWED DIVORCED | 12/6/03 @ 2 yrs. | |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | 1 1 1 (OI | IZEN OF WHAT |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 013. |
| James G. De Beboise | Catherine Machar | 0/4 |
| | INFORMANT Address | , /// |
| (Yes, no, or unknown) (If yes give wor or dotes of service) 2/6-46-29/8 | HUSband- James She | o/con |
| 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (o) ANCINOMOS | mo70815 | ONSET AND DEATH |
| 1737 DUE TO 01. 11 | | 1 45 4 |
| rise to immediate couse (a), | Toma | |
| stoting the underlying couse DUE TO | | |
| last. (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) | 19. WAS AUTOPSY PERFORMED? |
| None | | YES NO |
| OR CONTRIBUTING CAUSE OF DEATH (IF FITHER NOTIFY MEDICAL EXAMINER) | (Enter noture of injury in Port I or Port II of item 1B.) | |
| 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLA | | inty) (Stote) |
| Hour o.m. None 19 While of work of work | ctory, street, office bldg., etc.) | |
| 21. I certify that (I) (this hospital) attended the deceased fram_ | 11/15, 1967, to present, 19_ | _, that (1) (we) lo |
| | at death/accurred at 2/5 M, fram causes and an th | |
| 220. SIGNATURE | ATTENDING MED. STAFF 22b. DA | ATE SIGNED |
| plus. Inluces M. | | 2/30/67 |
| DAME (Type) TO HN B. UMHAY MD | 8805 Conn. Ave. Ch | an Chroke |
| 230. BURIAL (REMATION, PENOYALI (Specify) 4 Jan 1968 23C. NAME OF CEMETERY OR PARKLAWN | CEMATORY 23d. LOCATION (City or Town) | (County) (Stote) |
| Burrial) 4 Jan 1968 Parklawn | Rockville Mont | Md. |
| 24 FUNERAL DIRECTOR TO THE TOTAL THE ADDRESS TO THE | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SI | GNATURE |

Bethesda, Md

DATE JAN

1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotian, or removal, and in any event, within 72 hours after death.

unit or a contration as promised on the promise promise of their Contration of the c 47957 State of the state of the , 301

FOR STATE

HEALTH DEP

delay is

This certificate shauld be executed within 24 haurs after death. If

TO DEPUTY MEDICAL EXAMINER:

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | 17 | - | 10 | 4 | |
|-----|------|-----|-----|------|--|
| N. | 3 | and | n | 1 | |
| įl. | - 66 | 0.3 | 1.7 | - 17 | |
| | - | - | 40 | - 4 | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 4 | 344 | 0 | 0 | -4 |
|---|-----|---|---|----|
| - | - | 1 | D | 1 |

| | 1.4 | 3.0 |
|---|--|-----------------------------------|
| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residen | |
| o. COUNTY MONT 9 6 MARYLAND | o. STATE Mary land b. COUNTY MO | ntgemery |
| b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 1b | CETTY OR TOWN (If outside corporate limits, write RURAL and give | |
| write RURAL and give nearest town) | (R) Boyds- | 15-1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | d. STREET ADDRESS | e. IS RESIDENCE |
| Box 17 B | Box 17.B. | ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) WITH LATING. A ITHUT | Shiftet of Dec- | Doy Year 8 1967 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED | 8. DATE OF BIRTH Sept. 7, 1913 9. AGE (In yeors Introduction of the second of the seco | Doys Hours Min. |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired Jeri R INDUSTRY ding | 11. BIRTHPLACE (Stote or foreign country) 12. CIT CO | TIZEN OF WHAT |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| Elisah. Shiflet | Virginia. Fourer. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 | . INFORMANT Address | |
| (Yes, no, or unknown) (If yes give wor or dates of service) 284-07-6346 | Mrs. Margaret Simpson Shiflet, E | Boyds, Md. |
| 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) | | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) COFONZYY | Insufficeny Acute | Sudden |
| 4201 DUE TO | | |
| Conditions, if ony, which gove) (b) | | |
| rise to immediate couse (o), stating the underlying couse | | |
| lost. (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | D THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES NO |
| ☐ PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | D. (Enter noture of injury in Port I or Port II of item 18.) | |
| | PLACE OF INJURY (Hame, farm, octory, street, office bldg., etc.) | unty) (State) |
| 21. I certify that I taok charge of the remains described abave, | held an Autopsy 🔲 , Inspection 💢 , Inquiry 🔼 | and in my apinion |
| | uicide , Homicide Undetermined manner | |
| A | CHIEF MEDICAL EXAMINER | |
| SIGNATURE John J. Ball | M.D. ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| EXAMINER'S | M.D. ASSISIANT MEDICAL EXAMINER \(\Beta\) 12/9/6 | 7 |
| NAME (Type) | Address (Street, city, town, or county) | |
| 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O | | (County) (State) |
| Burial 13 Dec. 67 Mount Comfor | O Como Col 1 | /irginia |
| 24. FUNERAL DIRECTOR B Ende Mount HADDRESS | 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S S | |
| Cunningham-MountcastleFuneralHome, Woodb | oridge, Value DEC 13 1967 2000 | wee Judge |

2, and 3 ta PM3. Page 5 may be retained far yaur files. TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages land 2 with the State Department the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm in pencil in Item 18. Give Pages 1, Health priar ta burial, crematian, ar remaval, and in any event within 72 haurs after death. necessary, please execute the certificate, writing the ward "pending"

VR A15ME (5) 6M 1/67

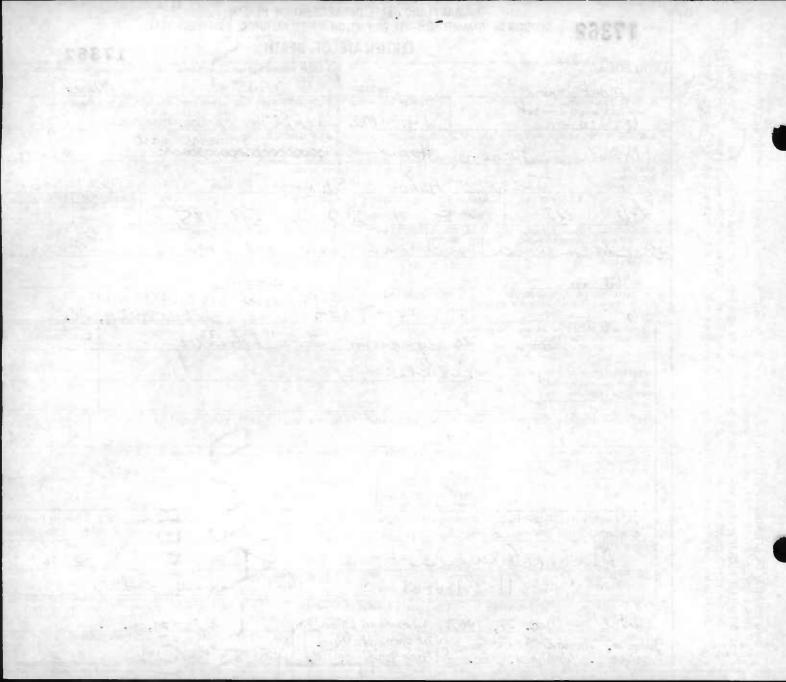
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-Oil

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | 1 6 0 0 0 | | | | |
|-----|--|--------------------------------|--|---|-------------------------------------|
| | | CERTIFICATE | OF DEATH | To be a little of | 17362 |
| | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where dec | eased lived if institution. F | Pasidance hafore admission) |
| | a. COUNTY | | o. STATE | b. COUNTY | Cosidence Delote Oditission) |
| _ | montgomen | MARYLAND | 11101 | | "811ant" |
| 1 | b. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corp | | |
| | (1) heaton | 141. 4mo | - Silver Sp | ring, Marule | and 15,1 |
| (| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, | give street address) | d. STREET ADDRESS 5 Bu | urket Court | e. IS RESIDENCE ON A FARM? |
| | University Nursing | Home | Maxima parce par | | YES NO |
| | NAME OF First | Middle | Last 4. DAT | E // Month | Doy Year |
| | (Type or print) Jesse | ASHBY S | shives DEA | TH Ruc. | 22, 1967 |
| | SEX 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED 8 | B. DATE OF BIRTH | | UNDER 1 YEAR IF UNDER 24 HRS. |
| | WIDOWED WIDOWED | | 2-26-1879 | 8 X Yrs. | onths Doys Hours Min. |
| 00. | | IND OF BUSINESS OR NDUSJRY | 11. BIRTHPLACE (County & Stote, or | foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| 4 | as Station Owner Gas | s Station | Hancock 1 | ma. | mer |
| 3. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| | Unknown | | Unknown | | |
| S. | | SOCIAL SECURITY NO. | NFORMANT Garner | 5 Burket Co | ount |
| 10 | s, no, or onknown, (in yes give wor or dores or service) | 79-26-853 | 9-1 | Silver Spri | |
| ٦ | 18. CAUSE OF DEATH (Enter only one couse per line for | | | · · | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: | a Syndrome | May 10 10 10 1 | m l.t. | ONSET AND DEATH |
| | 48/X IMMEDIATE CAUSE (o) | My ravama | - Jacket Naco | 7 | |
| | Canditions if any which area | R CVID. | | / | |
| | rise to immediate cause (a) | 1010 | | | |
| | stoting the underlying couse DUE TO | | | | |
| | lost. (c) | | | | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING | TO DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDITION G | IVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? |
| 2 | alimenticuli | ti. | | | YES NO TO |
| | | ESCRIBE HOW INJURY OCCURRED. (| Enter noture of injury in Port 1 or 1 | Port II of item 18.) | |
| 3 | OR CONTRIBUTING CAUSE OF DEATH | | | , | |
| H. | (IF EITHER, NOTIFY MEDICAL EXAMINER) | NJURY OCCURRED 20e. PLAC | E OF INJURY (Home, farm, 201 | f. (City or town) | (County) (Stote) |
| E D | Hour o.m. While | | ory, street, office bldg., etc.) | (City of fowli) | ((20114) |
| 11 | p.m. 19 ot wor | k L of work L | | // | 10 (7) |
| | 21. 1 certify that (I) (this haspital) atten | ded the deceased fram_/ | nay, 1967 | to Dec 22 | , 19 <u>67</u> , that (I) (we) last |
| 9 | saw the deceased alive an Luc. 1 | 8 19 $9/$, and that | death accurred at 11.30P | | |
| | 220. SIGNATURE | 0 . | ATTENDING MED. | STAFF 2 | 2b. DATE SIGNED |
| | Jusselle purjo | elect M.D | 111101 | PHYS. | Dec. 22, 1967 |
| | 22c. PHYSICIAN'S NAME (Type) RVSSELL OIL | BUFALINO | 22d. ADDRESS | ersity Blod | lu |
| | | | | | |
| 30 | REMOVAL (Specify) | 23c. NAME OF CEMETERY OR (| | LOCATION (City or Town) | (County) (Stote) |
| | Burnal Dec. 27, 196; | 7 Glenwood Ce | metery Wa | shington, D. | . (. |
| 24 | FUNERAL DIRECTOR Omas John Bolhomas | 8434ADDRESSOrgia A | | | RAR'S SIGNATURE |
| 9 | Varner E. Purphrey Inc. | Silver Spring. | Md. DAREC 28 | 1967 Och | nele a de |
| | | | The state of the s | 44 44 4 F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers: Pages | and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 hour rafter death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the haspital or attending physician. VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

514900

| | CERTIFICATE | OF DEATH | A | . 4003 |
|--|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY | | 2. USUAL RESIDENCE (Where de o. SJAJE | eceosed lived, if institution: Re b. COUNTY | esidence before odmission) |
| b. CITY OR TOWN (If outside corporate limits/ write RURAL and give neagest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside con | 10 0 1 | - 1 - |
| Kensington | | Nagersto | wn. Ma | 11/12 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in h Kensington garde | - 1 | d. STREET ADDRESS ROUTE # 8 |) | e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) Marty A | Middle VAIVE | SHIVES OF DE | ATH DEC. | Day Year 14 1967 |
| Female White w | IDOWED DIVORCED | B. DATE OF BIRTH 2.11.1879 | lost birthdoy) Mor | |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, a | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | COUNTY MU | U.S.A. |
| | | ELIZABETH BA | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of serv | ice) 16. SOCIAL SECURITY NO. 17. III | LEO YOUNKER | Address RURAL 2 HA | NCOCK MD. |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse [ast.] DUE TO (c) Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse (c) [ast.] | pronch. | Speneum ed seni | lity | 9 delys |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRI | BUTING TO DEATH BUT NOT RELATED TO T | THE TERMINAL DISEASE CONDITION | GIVEN IN PART I(0) | 19. WAS AUTOPSY PERFORMED? YES NO |
| 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or | Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. | | CE OF INJURY (Home, form, ory, street, office bldg., etc.) | Of. (City or town) | (County) (Stote) |
| 21. I certify that (I) (this hospital saw the deceased alive an | | Huf , 1967 t death accurred at 10/ | | 1962, that 🙀 (we) last an the date stated above. |
| 220. SIGNATURE Juanon | Wadler M.D | | STAFF C | 2b. DATE SIGNED 12/14/67 |
| 22c. PHYSICIAN'S NAME (Type) MARVIM | WAPLER | 22d ADDRESS & W | isc, fr. | Bethode My |
| 230. BURIAL, CREMATION, REMOVAL (Specify) | 7 23c. NAME OF CEMETERY OF CORCHARD RIC | DGE RU | JRAL HANCOC | (County) (StoteMD K WASHINGTON |
| 24. FUNERAL DIRECTOR | ADDRESS | 250. REC'D BY REC | a and d | AR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 moy be retained by the hospitol or ottending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the fundar director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in ony event, within 72 mours after depts. VR A15 (4) 25M 1/67

73 W32101 . . . 2 . . . av Maniferen Martau (sit all таци дяхнико 1 30. VI.SI

CERTIFICATE OF DEATH

| 19 | 344 | 0 | 0 | - | |
|------|-----|-----|-----|-------|--|
| - 2 | 7 | -4 | Dr. | 11. | |
| die. | - 0 | 6.3 | 5.2 | Gigs. | |

| | | | | | | | | | di | 101 | 24 | |
|---------------|---------------------|--|----------------|-------------------------|----------|---------------------------------|------------------|----------------------------------|-------------|----------|--------------------|---------------|
| | ACE OF DEATH | | | | 0.11 | 2. USUAL RESIDENCE (| Where dece | osed lived, if institu b. COU | | nce befa | re admissi | ion) |
| 0. | | toomerv | | MARYL | AND | Viroi | nia | b. C00 | N(1 | | 6 | |
| b. | CITY OR TOWN (| f outside corporate limit | s, | c. LENGTH OF STAY IN | | c. CITY OR TOWN (If or | | rate limits, write RU | RAL ond giv | ve neare | st tawn) | |
| | | give nearest town) | | | | C-13- | 05 | | | | 0.9 | . 3 |
| d | - | AL OR INSTITUTION (If no | at in basnital | give street address) | - | d. STREET ADDRESS | LOUI | cn | | | e. IS RESI | DENCE |
| u. | NAME OF HOSEII | AC OK INSTITUTION (II III | iii naspiiai, | dise zueer address) | | | | | | | ON A F | ARM? |
| | 1.11 | ty Nursing | Home | | | 6030 Vist | | | | | YES | NO X |
| | AME OF ECEASED | Fi | rst | Middle | | Last | 4. DATE | Man | th | Doy | Y Ye | ar |
| (T | ype ar print) | Arth | ur | James | | Shugars | DEAT | н Decem | ber | 3 | 19 | 67 |
| . SE | X | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | | B. DATE OF BIRTH | | 9. AGE (In years | IF UNDER | | | R 24 HRS |
| Ma | ale | Caus. | WIDOWED | DIVORCED | | 1/22/1889 | | last birthdoy) 78 yrs. | Months | Days | Hours | Min. |
| 111 | | (Give kind of work done | 10b. | KIND OF BUSINESS OR | | 11. BIRTHPLACE (County | & State, ar | | 12. C | ITIZEN O | F WHAT | |
| | | life, even if retired) | | INDUSTRY | | | | | ((| OUNTRY? | ? | |
| | hief En | gineer | | | | Louden Co | | Virginia | | USA | | |
| J. 1 | AIREK 2 NAME | | | | | 14. MOTHER 3 MAIDEN | NAME | | | | | |
| | ames Sh | | 100 60 7 | | | Cassandre | w Sto | | | | | |
| | | R IN U.S. ARMED FORCES? (If yes give war or dates o | | . SOCIAL SECURITY NO. | 17. 1 | NFORMANT | | Addr | ess | | | |
| (165, | Yes | World War | | 77-10-0399 | 1 | Delia H. | Shire | ars | | | | |
| T | | ATH (Enter only one cou | | | | | | | | IN | TERVAL BE | TWEEN |
| | | H WAS CAUSED BY: | 00 | pratory | 1 | 1200 | | | | ON | ISET AND | |
| | 334 | IMMEDIATE CAUSE | (0) | Troncing. | a | VIII | - | - | | 145 | mx | 14_ |
| | Conditions, if ony, | DUE | 10 | 124,000 | .7 | corela | | seulas | 1 | 1.0 | 1. | |
| | rise ta immediat | e couse (a) | (b) (A) | 12 10 5 ca | rou | e cever | ova | sewen | acces | uce | 6 | mo- |
| | stoting the under | | ТО | | | | | | | | | |
| 1 | ast. |) | (c) | | | | | | 20 | | | |
| Z | PART II. OTHER SI | GNIFICANT CONDITIONS C | ONTRIBUTING | TO DEATH BUT NOT RELA | TED TO | THE TERMINAL DISEASE CO | NDITION GI | VEN IN PART 1(o) | | 19. | WAS AUT PERFORM | OPSY MED 2 |
| CERTIFICATION | | | | | | | | | | Y | ES | NO [|
| | 20a. ACCIDENT WAS | UNDERLYING | 205. [| DESCRIBE HOW INJURY OCC | CURRED. | (Enter noture of injury in | Part I or P | ort II of item 1B.) | | | | |
| ž (| | CAUSE OF DEATH | | | | | | | | | | |
| | | MEDICAL EXAMINER) JRY Month, Day, Yeor | 204 | INJURY OCCURRED | 20° DI W | CE OF INJURY (Hame, farr | m. 20f. | (City or town) | 150 | ounty) | | (State) |
| MEDICAL | Hour o.n | | Whi | | | ary, street, office bldg., etc. | | (City of Town) | 100 | Julily | | (Sinia) |
| L | p.r | | of wo | ork Lat wark La | | | - | | | | | |
| | | | pital) atte | nded the deceased t | ram_4 | OCT 11. | 196/ | to DEC | 3, 19. | 6/1 | hat (I) (| we) lo |
| | saw the d | ecogsod alive an_ | 20 | EC 196/, 0 | nd tha | t death accurred at | 34 | M, fram causes | and an | the dat | te state | d abav |
| - | 22a. SIGNATURE | 01100 | 11/ | - // | | ATTENDING | MED | CTAFF | 22b. [| DATE SIG | YED _ | |
| | 18 | MATTIAL | 719-9 | 7//1 | 1.M | D. PHYS. | MED. DIRECTOR | STAFF PHYS. | 1/21 | 3/ | 67 | |
| 1 | 22c. PHYSICIAN'S | -au | / | 1 | | 22d. ADDRESS | | 1500 | / | 1 | - | |
| П | NAME (Type) | WALTER | SOORH | UMD | | 2304 SHO | REFIL | EUD RD | WH | EAT | ON 1 | 40 |
| 20 | BURIAL, CREMATIC | N. 23b. DATE TH | PLOE | 23c. NAME OF CEMET | EDV OD | CDEMATORY | 224 | LOCATION (City or To | lawa | Kounh | A (9 | [asas] |
| | REMOVAL (Specify | | | 25C. NAME OF CEME | LKT UK | CKEMATUKT | Z3d. | LOCATION (CITY OF IC | (WII) | (County | () | Stote) |
| | | Dec.6 | .1967 | Culpepe | | | | Culpeper. | Vira | | | |
| 24. | FUNERAL DIRECTO | 06 | | ADDRESS | 1100 | | D BY REGIS | | EGISTRAP'S | SIGNATU | KE | |
| 1 | Tank 0 | I Mump | - 4/1 | s tinorit | Low | DEC | 6 | 967 Jecc | - May | 1 | 0. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the Diversity director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbop papers, Pages 1 and

VR A1S (4) 20 M 1/66

17365 FOR STATE HEALTH DERT. necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with form. PM3. Page This certificate shauld be executed within 24 hours after death. If any delay is mentat

Depar

5 may be retained far your files. TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 with the State

Health priar ta burial, crematian, ar remaval, and in any event within 72 haurs after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17365

| 1 | | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Resider | ice before admission) | | | |
|---|---|--|---|---|--|--|--|
| - | (| o. COUNTY Maryland | o. STATE b. COUNTY | Mamera | | | |
| | ŀ | b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and giv | neorest town) | | | |
| | | write RURAL and air neorest town) Da A | Korduelle | 15 1 | | | |
| | (| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | d. STREET ADDRESS | e IS RESIDENCE ON A FARM? | | | |
| 9 | | Suburban | 734 Calleg Play | YES NO | | | |
| | | NAME OF First Middle | Lost 4. DATE Month | Doy Year | | | |
| | | DECEASED (Type or print) Brian Michael D | hulman DEATH Dee a | 22 1967 | | | |
| | S. 5 | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In yeors IF UNDER lost birthdoy) Months | 1 YEAR IF UNDER 24 HRS. Doys Hours Min. | | | |
| | | m widowed Divorced | 100-26/966 / Yrs. | | | | |
| | | . USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | ((| TIZEN OF WHAT | | | |
| | | Child - | Maryand | 45A | | | |
| | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| | 1. | Harry Dhulman | Myrna Harrison | | | | |
| | | s nd or unknown) (If we give wor or dotes of service) | INFORMANT Address | | | | |
| | 1 | VO NONE M | ather. Some as alo | | | | |
| | | 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) PART I. DEATH WAS CAUSED BY: | | ONSET AND DEATH | | | |
| 1 | | 9010 IMMEDIATE CAUSE (o) ASJONG XI 3 | | | | | |
| - | Conditions, if ony, which gove) (b) Aspiration of Food. Sudden | | | | | | |
| | | rise to immediate couse (a), | 1 000, | | | | |
| | | stoting the underlying couse | | - A 10 (A) | | | |
| | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY | | | |
| 2 | TION | That is only sometime to be the sound of the | THE TERMINAL DISEASE CONDITION OF EACH TO THE TANK THOSE | PERFORMED? | | | |
| | CERTIFICATION | 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or Port II of item 18.) | 1 70 L 110 KL | | | |
| | CERT | DDIAMA DV W ar CONTRIDITING | a of apple he uns eating | | | | |
| | MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLAC | CE OF INJURY (Home, form, 20f. (City or town) (Co | unty) (Stote) | | | |
| 5 | MED | Hour o.m. 12/22 1967 While Not While of work of work | ory, street, office bldg., etc.) Rockirlle Mo. | ntromery and | | | |
| | | 21. I certify that I took charge af the remains described above, he | | and in my apinian | | | |
| | | death resulted fram: Natural causes , Accident . Suici | | 7 | | | |
| | | | CHIEF MEDICAL EXAMINER | × 32 - 34 | | | |
| | | ACTUAL John S. Ball - | M.D. ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED | | | |
| | 3 | EXAMINER'S | DEPUTY MEDICAL EXAMINER 12-/22/ | 57_ | | | |
| 1 | | NAME (Type) | Address (Street, city, town, or county) | | | | |
| - | | BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR | 11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1 | (County) (Stote) | | | |
| | A | JURIAC 11/24/6/ VIDAIN BRA | TEL GOTTI, INCONTO | CONATURE | | | |
| | 29 | FUNERAL DIRECTOR ADDRESS | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S S | a Judge | | | |
| 9 | X | with sure How 4-2/1-7- | Red. DATEDEC 26 1961 | - 1 0 . | | | |

VR A15ME (5) 6M 1/67

TO DEPUTY MEDICAL EXAMINER:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STR STREET BALTIMORE MARYLAND 21201
OF DEATH

17366

| | PLACE OF DEATH | | | | on: Residence before odmission) |
|-----------------|--|--|--|---|--|
| (| o. COUNTY | MARYLAND | o. STATE arylan | | Montgo mery |
| ŀ | b. CITY OR TOWN outside corporate limits, | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (tf outside | | |
| 0 | write RURAL and give nearest town) | | | torpurate illinis, write kok | AL one give necress towny |
| | | esda lyr 3 mos. | | | 13 / |
| 0 | d. NAME OF HOSPITAL OR INSTITUTION (If not in | | GOOD LAST BEST | chill Drive | e. IS RESIDENCE ON A FARM? |
| | Bethesda-Silver Sprin | ng Nursing Home | CXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | OCIUTA XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | XXXXXXX YES NO |
| | NAME OF First DECEASED FIRST | Middle | 11 1 | DATE // Mont | |
| _ | (Type or print) | N J | bert | DEATH / 2 | |
| 5 | | MARRIED NEVER MARRIED | B. DATE OF BIRTH | 9. AGE (In years lost birthdoy) | Months Doys Hours Mi |
| 6 | emple Caucasian w | /IDOWED M DIVORCED | Jan 30, 180 | 96 71 yrs. | Molitilis Doys Hours Mil |
| | . USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & Sto | | 12. CITIZEN OF WHAT |
| Juri | ing most of working life, even if retired) | INDUSTRY | West Vin | | COUNTRY? |
| 13 | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAM | ginia. | U.D.A. |
| 10. | Van Shelby Perkins | | Frances Wil | | |
| | | | | | |
| 15. | was Deceased Ever In U.S. ARMED FORCES? is, no, or unknown) (If yes give wor or dotes of serv | 16. SOCIAL SECURITY NO. 17. | INFORMANT | Addre | |
| (10. | No | 403-01-8586 D B | oyd Sibert - S | See Item No. | 2 |
| T | 18. CAUSE OF DEATH (Enter only one couse pe | | | | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: | | -1 - Th | and bearing | ONICET AND DEATH |
| | 332 × IMMEDIATE CAUSE (o) = | Cerebral A | rotery (h | rombosis | Z week |
| | DUE TO | 1 1 1 | 11 001 | | |
| | Conditions, if ony, which gove (b) | Cerebral 1 | Irtem Scle | 4051S | years |
| | stoting the underlying couse DUE TO | | 7 | | |
| | last. (c) | | | | |
| | DADT II OTHER CICALFICANT COMPLETIONS CONTR | | THE TERMINAL DISEASE COMPLET | ON CIVEN IN PAPT 1(a) | 19. WAS AUTOPSY |
| - | I PAKI II. UTREK SIGNIFICANT CUNDITIONS CONTR | IBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITI | | |
| NO. | PART II. OTHER SIGNIFICANT CONDITIONS CONTR | IBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITI | ON OIVER IN PART I(O) | PERFORMED? |
| ICATION | | | | | |
| RTIFICATION | 20o. ACCIDENT WAS UNDERLYING □ | 20b. DESCRIBE HOW INJURY OCCURRED. | | | PERFORMED? |
| CERTIFI | | | | | PERFORMED? |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED 20e. PLA | (Enter noture of injury in Port | | PERFORMED? YES NO |
| 프 | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED 20e. PL/While Not While | (Enter noture of injury in Port | I or Port II of item 18.) | PERFORMED? YES NO |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work for | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | I or Port II of item 18.) 20f. (City or town) | PERFORMED? YES NO (County) (Stote |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this hospital | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED for on work of work o | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | I or Port II of item 18.) 20f. (City or town) | PERFORMED? YES NO (County) (Stote |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED for on work of work o | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | I or Port II of item 18.) 20f. (City or town) | PERFORMED? YES NO (County) (State 1967, that (I) (we) and an the date stated ob |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this hospital | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED for on work of work o | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | 20f. (City or town) 2 ta Dec 2 M, from causes | PERFORMED? YES NO (County) (State |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Not While of work of work 1) attended the deceased fram 1967, and the | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) It death accurred at 2 ATTENDING AMERICAN | 20f. (City or town) 2 ta Dec 2 M, from causes | PERFORMED? YES NO (County) (State , 1967, that (I) (we) and an the date stated ob |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an 22o. SIGNATURE | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED for otwork of work 1967, and the | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) ACE OF INJURY (Home, form, form, tory, street, office bldg., etc.) ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | 20f. (City or town) 20f. (City or town) 2 ta Dec 2 10 M, from causes of STAFF 10 CTOR PHYS. | PERFORMED? YES NO (County) (State , 1967, that (I) (we) and an the date stated ob 22b. DATE SIGNED |
| CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an Decease of the saw the deceased alive and Decease of the saw the deceased alive and Decease of the saw the deceased alive and Decease of the saw the sa | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED for otwork of work 1967, and the | (Enter noture of injury in Port ACE OF INJURY (Home, form, tory, street, office bldg., etc.) ACE OF INJURY (Home, form, form, tory, street, office bldg., etc.) ACE OF INJURY (Home, form, tory, street, office bldg., etc.) | 20f. (City or town) 20f. (City or town) 2 ta Dec 2 10 M, from causes of STAFF 10 CTOR PHYS. | PERFORMED? YES NO (County) (State , 1967, that (I) (we) and an the date stated ob 22b. DATE SIGNED |
| MEDICAL CERTIFI | 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an Deceased Signature 22c. PHYSICIAN'S NAME (Type) Robert | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While Otwork Otwork Office of two the otwork of the deceased fram 1967, and the face of the otwork | (Enter noture of injury in Port ACE OF INJURY (Home, form, fory, street, office bldg., etc.) ACE OF INJURY (Home, form, form, fory, street, office bldg., etc.) ACE OF INJURY (Home, form, fo | 20f. (City or town) 2 ta Dec 2 PM, from causes of the Cook of Phys. | PERFORMED? YES NO (County) (Stote 1, 1967, that (I) (we) and an the date stated ob 22b. DATE SIGNED Are DC, |
| MEDICAL CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an Decease of the control of t | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED Solve of work of two of t | (Enter noture of injury in Port ACE OF INJURY (Home, form, fory, street, office bldg., etc.) ATTENDING MED DIR 22d. ADDRESS CREMATORY | 20f. (City or town) 20f. (City or town) 2 ta Dec 2 M, from causes of the phys. CTOR PHYS. Webraska 23d. LOCATION (City or Town) | PERFORMED? YES NO (County) (Stote 1967, that (I) (we) and an the date stated ob- 22b. DATE SIGNED Are DC, yn) (County) (Stote) |
| MEDICAL CERTIFI | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour'o.m. p.m. 19 21. I certify that (I) (this hospital saw the deceased alive an Decease of the control of t | 20b. DESCRIBE HOW INJURY OCCURRED. 20d. INJURY OCCURRED While of work of owork of otwork of otwork of otwork of otwork. 3 the occurrence of the occurrence of otwork of otwork of otwork of otwork. 3 the occurrence of occurrence occurrence of occurrence occurrence of occurrence | (Enter noture of injury in Port ACE OF INJURY (Home, form, forry, street, office bldg., etc.) ACE OF INJURY (Home, form, forry, street, office bldg., etc.) ACE OF INJURY (Home, form, form, forry, street, office bldg., etc.) ACE OF INJURY (Home, form, forry, street, office bldg., etc.) ACE OF INJURY (Home, form, forry, street, office bldg., etc.) | I or Port II of item 18.) 20f. (City or town) 22 ta Dec 2 PM, from causes of the phys. COOR PHYS. 23d. LOCATION (City or Town) | (County) (Stote of County) (St |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs aften Page 4 may be retained by the hospital or attending physicion. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carban pipers. Pages VR A15 (4) 25M 1/67

metallices are the production of the party 5 of the same and the same of The second section is a second section of the second section in the second section is a second section of the section of the second section of the section of the section of the second section of the section o the little of the latter of th

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Page 4 may be retained by the hospital or attending physician.

3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Seem #2a, b, c & d Film#G396 CERTIFICATE OF DEATH

17367

| Thom #22,0,0 and Think 422 GERTIFICAT | E OF DEATH | 367 |
|--|--|-------------------------------|
| 1. PLACE OF DEATH a. CDUNTY | 2. USUAL RESIDENCE (Where deceased lived, If institution: Re | esidence before admission) |
| | a. STATE Md. b. COUNTY | Iont. |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) | c. CITY DR TDWN (If outside corporate limits, write RURAL | and give nearest town) |
| STIVER SORTING WITH | Silver Spring | 15.1 |
| d. NAME OF HOSPITAL OF INSTITUTION (if not in hospital, give/street address) | d. STREET AOORESS | 8. IS RESIDENCE DN A FARM? |
| DELLA VISTA NURSING HOME. | 10430 Brookmore Drive | YES NO |
| 3. NAME DF DECEASED (Type or print) TILE MIddle HAUKE | Last 4. DATE Month | Oay Year |
| C ACK | 8. OATE DE BIRTH 9. AGE (In years IFUNDER: | 6 196/ |
| 6. CDLDR OR RACE 7. MARRIED NEVER MARRIED DIVORCEO DIVORCEO | Sent to 1880 last birthday) Months | Oays Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KINO OF BUSINESS OR | | TIZEN DF WHAT |
| Deducal Strift - Relived Fredrick Horel | Gacoma Washington 00 | 1. S. A |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| Churles Hauke_ | Carrie Duncan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unkown) (If yes give war or dates of service) | INFORMANT Address 10 4 | 30 BROOKMINE |
| MA | SMADME DULLIVAN TIP | 5.5. Mr. |
| 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN |
| PART I. OEATH WAS CAUSED BY: Cerebool T | h 7-4 6-315 | ONSET AND DEATH |
| 442 × OUE TO | 0 0 | 1 > 1 |
| Conditions, If any, which) (a valo - Va; | scole: Menel Discore | / Yr. |
| gave rise to immediate (cause (a), stating the OUE TO | | |
| underlying cause last. (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELI | ATEO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTDPSY PERFORMEO? |
| ICA. | | YES NO |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELIGIOUS CONTRIBUTING TO DEATH BUT NOT RELIGIOUS CONTRIBUTING CAUSE OF DEATH CONTRIBUTING TO DEATH BUT NOT RELIGIOUS CONTRIBUTION CONTR | URREO. (Enter nature of injury in Part I or Part II of item 18.) | |
| 3 20c. TIME DF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLA | ACE OF INJURY (Home, farm, 20f. (City or town) (Cour | nty) (State) |
| 20c. TIME DF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20d. INJ | ory, street, office bldg., etc.) | |
| | 10/16 . 1967 to 12/6 . 196 | Z that (I) (we) last |
| | t death occurred atM, from the causes and on th | |
| 22a. SIGNATURE | ATTENOING MEO. STAFF 22b. DA | TE SIGNED |
| 22c. PHYSICIAN'S | D. PHYS. DIRECTOR PHYS. 1 | 10- |
| NAME (Type) Herold) elges | 5415 Con Are 1 | N DC |
| 236. BURIAL) CREMATION, 23b. OATE THEREOF 23C NAME OF CEMETER | Y OR CREMATORY 23d, LOCATION (City, town or coun | nty) (State) |
| 24. FUNEDAINDIRECTOR 1967 LANDERSS ADDRESS | medery taknighen | N.6. |
| 254 Gerral A | 252 REC'D BY REGISTRAR Sb. REGISTRAR'S | SIGNALINE |
| Junior Janese 7.619 | DATEDEC 11 1967 galland | es fregge |

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17368

CERTIFICATE OF DEATH

| 1 | | | | | | | | 100 | Um | |
|--|---|---|----------------------|-----------------------------|---|-----------------------------|---|------------------------------------|----------------------------|-------------------|
| | 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | AND | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATMaryland b. COUNTY | | | | | |
| b. | b. CITY OR TOWN (if outside corporate limits, write RURAL and sive neons town) 56 days | | | | 1 1b | c. CITY OR TOWN (If ou | tside corporate limits, write RUI | RAL and give neon | rest town) | - 1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Naval Hospital | | | | | d. STREET ADDRESS 4513 Rena | Road | | e. IS RESII ON A F | DENCE ARM? NO X | |
| DE | AME OF ECEASED ype or print) | First Frank | | Middle Kane | SLA | Lost | 4. DATE Mont | h D | oy Ye | |
| S. SE | | | . MARRIED WIDOWED | NEVER MARRIED DIVORCED | | ay 22, 1913 | 9. AGE (In years | Months Days | IF UNDER | |
| | | (Give kind af wark dane ite, even if retired) | 10b. KI | ND OF BUSINESS OR DUSTRY | | 11. BIRTHPLACE (County | & Stote, or foreign country) and. New York | 12. CITIZEN COUNTR' | | Α |
| | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN N | | | | |
| 15. V | WAS DECEASED EVE | R IN U.S. ARMED FORCES? (If yes give wor ar dates of s | 16. 561 | SOCIAL SECURITY NO. | | NFORMANT Apt. | 409, Chevy Otts Schumann, 510 | | t Ave | |
| () r | | e couse (o), | Civv | | Live | 21 | | | NTERVAL BET DNSET AND D | |
| ATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS PERI YES [| | | | | | | 9. WAS AUTO PERFORM YES | | |
| ER! | 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJURY Manth, Day, Yeor Hour a.m. p.m. 20d. INJURY OCCURRED While of work at wark of foctory, street, office bldg., etc.) 20e. PLACE OF INJURY (Hame, form, foctory, street, office bldg., etc.) | | | | | | | | State) | |
| | saw the de | y that (X) (this haspit ceased alive an | al) attend | ded the deceased t | ram_ N nd that | ov. 5 , 1 death accurred at | 9.67 , ta Dec . 3 1454 M, fram causes | 1, 19 <u>.67,</u> and an the do | that (½) (ate stated | we) las Labave |
| | 220. SIGNATURE | n (Slace | hhu | n | M.D | 111791 | MED. STAFF DIRECTOR PHYS. & | Jan. | | 68 |
| | 22c. PHYSICIAN'S NAME (Type) | | | ourn, M. D. | | | Hospital, Bet | | Md. | |
| Bu | BURIAL, CREMATIC REMOVAL (Specify) | 1/4/68 | 3 | 23c. NAME OF CEMEN | | tional | 23d. LOCATION (City or Ton | /irginia | | itote) |
| | | Falls Churc Broad St., F | | | rgin | | | GISTRAR'S SIGNAT | | £1 |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remayal, and in any event, within 72 haurs after death. 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

THE RESERVE OF THE PARTY OF THE inclused. of Chymanical STOY WENT , Med To Land , New York John H. - Theres sol 50 35-1 Miss ligher B. Schumenn. 130 lexact Mas. ned to E you at Tomas of the second sec alabasi , orașită la difem autorită autorită antici en la difemilia di Assaul III de la difemilia di Assaul II de la difemilia

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Aug. 169, Cherry Cherc, Mc.

Birth of Late and Market

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

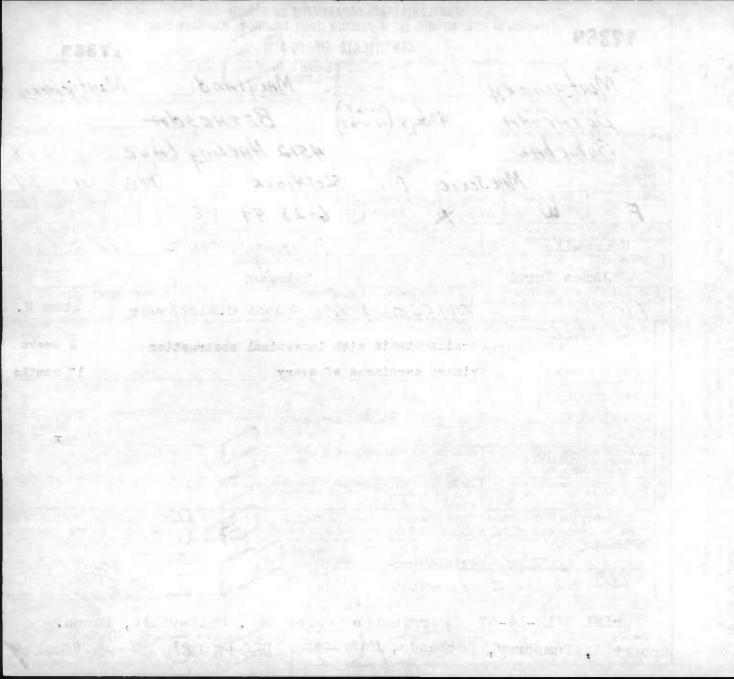
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17369

| | | | 7.4 | UU |
|---|-------------------------------------|----------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY | | 2. USUAL RESIDENCE (Whe | re deceased lived, if institution: Resider b. COUNTY | nce befare admission) |
| MONT GOMERY | MARYLAND | MAKYL | And 146 | INT gomery |
| b. CITY OR TOWN (If outside corporate limits) write RURAL and give nearest town), | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outsid | e corparate limits, write RURAL and giv | e neorgst town) |
| BETHESOA | 97days (12-11-67 | BE: | THESDA | 13/ |
| d. NAME OF HOSPITAL OR INSTITUTION (If nat in hasp | ital, give street address) | d. STREET ADDRESS | . , | e. IS RESIDENCE ON A FARM? |
| Subur bAN | | 4512 HA | Ching LANE | YES NO |
| 3. NAME OF Pirst DECEASED (Type or print) APE TO | Middle | SLOTHOWER 4 | OF DEATH DEC | Day Year |
| S. SEX 6. COLOR OR RACE 7. MARI | RIED NEVER MARRIED 8 | B. DATE OF BIRTH | 9. AGE (In years IF UNDER | The state of the s |
| F W WIDOW | WED DIVORCED | 6-28-99 | Sest birthdoy) Months yrs. | Days Haurs Min. |
| 10a. USUAL OCCUPATION (Give kind of work dane | Ob. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & St | | TIZEN OF WHAT |
| during mast of working life, even if retired) | INDUSTRI | Tennsyh | vania C | 1. D.U. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAM | E | |
| James Turck | | Unknown | | |
| IS. WAS DECEASED EVER IN U.S. ARMED FORCES? | | NEORMANT | Address Sam | e as |
| (Yes, and o) unknown) (If yes give war ar dates of service) | 577.54 2634 0 | m John | H.Slothower | Item 2. |
| 18. CAUSE OF DEATH (Enter only one cause per lin | ne far (a), (b), and (c),) | 010 | | INTERVAL BETWEEN |
| PART I DEATH WAS CAUSED BY | rcinematesis with | | | ONSET AND DEATH |
| 1750 DUE TO | Let Linear Cay In Miles | I INCOS CINAL | eostruction | O HEEKS |
| | imary carcinoma | of every | | 12 months |
| rise to immediate couse (o), | J | | | |
| stating the underlying cause (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUT | TING TO DEATH BUT NOT PELATED TO I | HE TERMINAL DISEASE CONDIT | ION CIVEN IN PART 1(a) | 19. WAS AUTOPSY |
| NO TAKE II. OTHER SIGNIFICANT CONDITIONS CONKIDUT | ING TO DEATH BUT NOT KEERIED TO T | THE TERMINAL DISEASE CONDIT | ION GIVEN IN PART I(U) | PERFORMED? |
| S - ACCIDENT WAS INDEDIVING ET | OF OCCUPATION WHILE OCCUPATION A | r | 1 - 0 - 4 11 - 1 2 10 \ | YES NO |
| OR CONTRIBUTING CAUSE OF DEATH | Db. DESCRIBE HOW INJURY OCCURRED. (| Enter nature of injury in Part | I at Part II at item 18.) | |
| | | E OF INJURY (Home, farm, | 20f. (City or town) (Co | unty) (State) |
| p.m. 19 | While Nat While facto | ary, street, affice bldg., etc.) | | |
| 21. I certify that (I) (this haspital) a | | TAN 19. | 56, to DIRC , 19 | that (1) (we) last |
| saw the deceased ative an DE | C X.O 1967, and that | | M, fram causes and an t | |
| 220. SIGNATURE | | ATTENDANO | | ATE SIGNED 7 |
| | non | ATTENDING ME | ECTOR PHYS. | 111/67 |
| 22c. PHYSICIAN'S | | 22d. ADDRESS, | | 111 |
| NAME (Type) DR LEO I | DONOVAN | 8218 W | scowsin Aux | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR C | REMATORY | 23d. LOCATION (City or Town) | (County) (Stote) |
| REMOVAL Specify 12-14-67 | Warrington (| Duaker Cem | Wellsville, P | |
| 24 FUNEDAL DIDECTOR | 223QUUA | aca perin pi | | |
| Robert A. Pumphrey, E | Bethesda, Mary | | 1 5 1967 Rollary | Eas Judge |

10 HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death **TO FUNERAL DIRECTOR:** After this certificate has been signed by the ottending physician ond completely filled in by the director, page 3 should be detached for use as the buriol-transit permit. Then please remave corbon papers—Pages should be filed with the State Dept. of Health prior to burial, cremotian, or removal, and in any event, within 72 hours at Poge 4 moy be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212017370 *Also knownas SCHMITZ within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY a. COUNTY ONTGOME MARYLAND b. CITY OR TOWN (If outside carporate limits c. LENGTH OF STAY IN 16 c. CITY OR (If autside corporate limits, write RURAL and give nearest tawn write RURAL and give nearest town) PARK d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO 4. DATE NAME OF Last Manth Day Year campletely 1 nave carban pan DECEASED ELORA 196 (Type or print) DEATH certificate be executed 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remave last birthday) Manths Days Hours and WIDOWED DIVORCED pup 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR = during most of working life even it retired) COUNTRY? physician c and 14 MOTHER'S MAIDEN, NAME emayal avalable 9 attending p 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address ATTENDING PHYSICIAN: The law requires that the death (Yes, na, ar unknown) (If yes give war ar dates of service 0 an, INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) cremati Z ONSET AND DEATH burial-transit PART I DEATH WAS CAUSED BY þ DUF TO signed burial Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause priar to the has been last OS WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe Health p NO Z certificate 10 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING of OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year this factory, street, affice bldg., etc.) Hour a.m. Nat While While State at wark at work TO FUNERAL DIRECTOR: After pe 21. I certify that (1) (this haspital) attended the deceased from. shauld the and that death accurred at or M, fram causes and an the date stated above. saw the deceased alive an with 22b. DATE SIGNED 22a. SIGNATURE DIRECTOR director, page 3 shauld be filed v M.D PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) LOGATION_(City or Town) BURIAL CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURI 2So. REC'D BY REGISTRAR **EUNERAL DIRECTOR** VR A15 (4) 20 M 1/66

07811 THE DESCRIPTION OF THE PARTY.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH 1 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1 PLACE OF DEATH TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours oft hours **TO FUNERAL DIRECTOR:** After this certificate has been signed by the ottending physicion and completely filled, director, page 3 should be detoched for use as the buriol-transit permit. Then please remove corbon page director, page 3 should be detoched for use os the buriol-tronsit permit. Then pleose remove corbon pay should be filed with the State Dept. of Heolth prior to buriol, cremation, or removal, ond in ony event, within Poge 4 may be retoined by the hospital or attending physicion.

| 1000 KOMERC/ MARYLAND | Mary land Mortgonery | | | | |
|---|---|--|--|--|--|
| b. CITY OR ADWN (If outside corporate limits, Write RURAL and give nearest town) Supering RURAL and give nearest town | c. CITY, OR DWN (If autside carparate limits, write RITRAL and give negrest tawn) | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) | d. STREET ADDRESS e. IS RESIDENCE | | | | |
| Suburban Hospital | 43/1 Independence ST YES NO 1 | | | | |
| 3. NAME OF First Middle DECEASED (Type or print) NAJELINE E. | Smith OF DEATH Dec. 11 1967 | | | | |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | 8. DAJE OF BIRTH 9. AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Haurs Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? 4.5 A | | | | |
| 13. FATHER'S NAME William B. Rudy | 14. MOTHER'S MAIDEN NAME About the Smith | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor or dates of service) 579-12-6893 Ac | Address Same as alone aughter . arline Smith | | | | |
| 18. CAUSE OF DEATH (Enter only one couse per line/for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a), stating the underlying couse last. (c) | 7 C Myn Chepnemus INTERVAL BETWEEN ONSES AND CEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO | | | | |
| OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | (Enter noture of injury in Port I or Part II of item 18.) | | | | |
| p.m. 19 at work LJ of work | CE OF INJURY (Home, farm, lary, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | |
| | t death accurred at Lula HoM, from causes and an the date stated above. | | | | |
| 220. SIGNATURE Jay 18 huger M. | | | | | |
| 22c. PHYSICIANS J. R. Shapiro | 8218 Wisconsin Ave, Bethesda, Md. | | | | |
| 230. BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR Mifflinbus | crematory 23d Location (City or Town) (County) (State) Mifflinburg, Pa. | | | | |
| 24 FUNERAL DIRECTOR Tyson Wheeler 1331 Rockville Maryland | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATEDEC 15 1967 Climber Question | | | | |

VR A15 (4) 25M 1/67

.gelt fasaftsvoll leafor late them beganning 3 days TERRI MISCORELE NOV. Suchadar, IL. · And the rest of the later ground Chief - 20/21/51 - indicate the tent Teron Sheeler deleving Revised

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| CERT | | ATE | OF | DEA | TILL |
|-------|-------|-----|-----|---------------------|------|
| I FKI | 11-11 | | 132 | $\Pi \vdash \Delta$ | I M |
| | | | | | |

| | | PLACE OF DEATH o. COUNTY | | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. STATE b. COUNTY MONTGOMERY | | | | |
|---|---|--|---|---|-------------------------------------|-----------------------------------|--|--|
| | b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b | | | C. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) | | | | |
| 1 | | write DIIDAI and sive negreet town | 4 DAYS | SILVER | SPRING | 15 | | |
| | _ | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give | street oddress) | d STREET ADDRESS | | e. IS RESIDENCE | | |
| 8 | 1 | HOLY CROSS HOSP. | | 9405 A | VENEL ROAL | ON A FARM? YES NO | | |
| | | NAME OF First DECEASED (Type or print) OLIVER | Middle Tames | SMITH | 4. DATE Mon | 27 1967 | | |
| | | SEX 6. COLOR OR RACE 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | 8. DATE OF BIRTH 3/1/95 | 9. AGE (In years lost birthday) | Months Doys Hours Min. | | |
| | duri | ring most of working life, even if retired) NDUS Retired Agent Onter | | 11. BIRTHPLACE (County Kentucky | & Stote, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| | 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN I | NAME | | | |
| | | Major D. Smith | | | inaelton | | | |
| - | 1S. (Ye | es, no, or unknown) (If yes give wor or dotes of service) | 17. 17. 17. 17. 17. 17. 17. 17. 17. 17. | Eva M. Smit | h Silver Spr | is Road Line. Md. | | |
| 5 | | 18. CAUSE OF DEATH (Enter only one couse per line for (o), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | (b), and (c).) e. developed | yasular acc | ident | INTERVAL BETWEEN ONSET AND DEATH | | |
| 6 | | 33/X DUE TO | 1. 1 + | | | 6 | | |
| | | rise to immediate cause (a), | ralized arl | erioselevois | | Severalyean | | |
| | | stoting the underlying couse DUE TO last. (c) | | | | | | |
| 1 | ATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D | BUT NOT RELATED TO | THE TERMINAL DISEASE COM | NDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES NO | | |
| | L CERTIFICATION | 20₀. ACCIDENT WAS UNDERLYING ☐ 20₺. DESCRI OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | BE HOW INJURY OCCURRED. | (Enter noture of injury in | Port I or Port II of item 18.) | | | |
| | MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d. INJURY While of work | | CE OF INJURY (Home, farm tory, street, office bldg., etc.) | | (County) (State) | | |
| | | 21. I certify that (1) (this hospital) attended sow the deceased alive on December. | the deceosed from | December 23 1 t death occurred of | 967, to December 33ºAM, from couses | ond on the dote stoted obove | | |
| | | 220. SIGNATURE Sennet a. Port | est. M. | ATTENDING D. PHYS. | MED. STAFF DIRECTOR PHYS. | 22b. DATE SIGNED December 27/1967 | | |
| 1 | | 22c. PHYSICIAN'S Bennet A. Po | rter Jr M | P 930 (Col. | esville Rd., St | reispring Md. | | |
| | 230 | b. BURIAL, CREMATION, REMOVAL (Specify) Dec. 29 1967 | 23c. NAME OF CEMETERY OR | CREMATORY La Cemetery | 23d. LOCATION (City or To | own) (County) (State) | | |
| 4 | 100 | | 34 ADDRESSigia A | verue 250. REC'E | BY REGISTRAR 25b. RE | EGISTRAR'S SIGNATURE | | |

haurs after death

ages Vand 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely titled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon gapers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs offer death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Page 4 may be retained by the haspital ar attending physician.

THE DESIGNATION OF THE PROPERTY OF THE PROPERT THE RESERVE OF THE PARTY OF THE

FOR STATE

1. PLACE OF DEATH COUNTY

HEALTH DEPT.

deloy

puo

in pencil in Item 18. Give Pages 1,

pending

writing the word

please execute the certificate,

should

certificate

PM3.

permit. File pages lond2 with the Store Depart

and in any event within 72 hours ofter death

o burial-transit

OS

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER

| STOR STREET, DALTIN | OKL, MAKILAND ZIZOI | | |
|--|---|-----------------------|-------------------------------------|
| S'S CERTIFICATE | OF DEATH | 173 | 73 |
| 2. USUAL RESIDENCE | (Where deceosed lived, if instituted by COU | tion: Residence b | efore odmission) |
| | outside corporate limits, write RU | MAL and give ne | ntest tawn) |
| d. STREET ADDRESS | 7. | /5 | e. IS RESIDENCE ON A FARM? |
| 0103 Tr | INCETON AVE | | YES NO |
| Smith | 4. DATE Mon | th | 8 1967 |
| B. DATE OF BIRTH | 9. AGE (In years lost birthdoy) | Months Do | |
| 1) BIRTHPLACE (State | e or foreign country) | 12. CITIZEN COUNTI | OF WHAT |
| 14. MOTHER'S MAIDEN | NAME | | |
| 17. INFORMANT | Addr | ess ade | 1 sine |
| Catherine . | E. Smite - w | y) | |
| Insuttice | ney Acute | 4 | INTERVAL BETWEEN ONSET AND DEATH |
| | , | | |
| | | | |
| | | | |
| TO THE TERMINAL DISEASE CO | ONDITION GIVEN IN PART 1(0) | , | 19. WAS AUTOPSY PERFORMED? YES NO |
| RED. (Enter noture of injury in | Part I or Part II of item 1B.) | | |
| PLACE OF INJURY (Home, far foctory, street, office bldg., etc. | | (County) | (State) |
| | Inspection X; Inq | | and in my apinian |
| Suicide , Hamicid | I EVAMINED | | |
| M.D. ASSISTANT ME | DICAL EXAMINER () | 2/18/6 | 22. DATE SIGNED |
| Address (Stre | et, city, town, or county) Be | | |
| OD COTHATORY | I DOLL LOCATION (CA T. | \ IF | - 4 - 1 (C4 - 4 - 1 |

CITY OR TOWN (If outside separate limits, c. LENGTH OF STAY IN 1b write, RURAL and give negrest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) NAME OF Middle DECEASED (Type or print) 6. COLOR, OR RACE 7. MARRIED WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY remoles 13. FATHER'S NAME WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCUR CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e 21. I certify that I taak charge of the remains described above death resulted fram: Natural causes X', Accident ACTUAL SIGNATURE **EXAMINER'S** JOHN G. BALL NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Burial Specify) 12-20-67 Ft. Lincoln Cemetery 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE PUMPHREY, Bethesda, Maryland DEC 26

the funeral director. Page 4 should be forworded to the Chief Medical Examiner's Office olong with form 5 may be retained for your tiles.

10 FUNERAL DIRECTOR: Page 3 should be used Health prior to buriol, cremation, or removal, VR A15ME (5) THE RESIDENCE OF THE PROPERTY OF THE PROPERTY

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

3)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| 1. | PLACE DF DEATH | | 2. USUAL RESIDENCE (Where | deceased lived, If institution; R | esidence before admission) |
|---------------|--|----------------------------------|----------------------------------|-----------------------------------|-------------------------------|
| | a. COUNTY Montgomery | ******* | a. STATE Marvlan | d b. COUNTY Mon 1 | gomerv |
| - | | MARYLAND LENGTH OF STAY IN 1b | c. CITY OR TOWN (if outside | | 0 |
| | _write RURAL_end give nearest town) | | | corporate minus, write KOKAL | and give nearest town) |
| | | 11 months | Takoma Park | | 5-1 |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp | Ital, give street address) | d. STREET ADORESS | | e. IS RESIDENCE ON A FARM? |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp Colonial Villa Nursing Home 12325 New Hampshire Ave., S | il. Sp., Md. | 37 Philadelphi | a Ave, Takoma 1 | Parkes No R |
| 2 | | | | | |
| ٥. | OFCFASFO . // | Middle / | Last 4. OA | | Oay Year |
| | | TOLDEN SPI | RINGMANN OF | ATH Dec. | 22 19 67 |
| 5. | SEX 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED 7 8 | B. DATE OF BIRTH | 9. AGE (In years IF UNOER | |
| | F WHITE WIDOWED IN | DIVORCEO | 8-12-85 | last birthday) Months 82 yrs. | Days Hours Min. |
| 10a | . USUAL OCCUPATION (Give kind of work done 10b. KINO | OF BUSINESS OR | 11. BIRTHPLACE (County & St | ate, or foreign country) 12. C | TIZEN OF WHAT |
| dur | 1/2 2 11/22 | JSTRY | RALTIMES | MD CO | OUNTRY? |
| 12 | MOMEMAKEK AT | HOME | BALTIMERE, | | US |
| 13. | 0 - 1 - 1 | | 14. MOTHER'S MAIOEN NAME | | |
| | CHARLES REANEY | | | | |
| 15 | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SO(| CIAL SECURITY NO. 17. | INFORMANT | Address | |
| (10 | 218 | -56-8935-7 N | Nursing Home Rec | orde | |
| | 18. CAUSE OF OEATH [Enter only one cause per line | | tarbing nome kee | ords | I INTERVAL BETWEEN |
| | | | | | ONSET AND DEATH |
| | IMMEDIATE CAUSE (a) | RONCHAPMI | EUN9 dix 1A | | 3 0462 |
| | 4200 DUE TO A | | | | |
| | Conditions, If any, which \ (b) AQT | FRIO SCLEA | OTIC HEART | DISRAS4 | 17 46 AKS |
| | gave rise to ininiediate | | | | |
| | underlying source look | | | | |
| N | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIN | NO TO DEATH DUT NOT DELA | TED TO THE TEDMINAL DIOPAGEO | ONDITION OF VEH IN BART 1/a) | 119. WAS AUTOPSY |
| Ĕ | PARTITIONER SIGNIFICANT CONDITIONS CONTRIBUTE | NG TO DEATH BUT NOT KELA | TED TO THE TERMINAL DISEASE C | UNDITIONGIVEN IN PART 1(a) | PERFORMED? |
| /2 | | | | | YES NO |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. DES | CRIBE HOW INJURY OCCU | RRED. (Enter nature of Injury In | Part I or Part II of Item 18. |) |
| CEF | OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| AL | 20c. TIME OF INJURY Month, Oay, Year 20d. INJU | RY OCCURRED 20e. PLAC | CE OF INJURY (Home, farm, 201 | . (City or town) (Cou | nty) (State) |
| MEDICAL | Hour a.m. While - | J NOT ALUE | ry, street, office bldg., etc.) | | |
| Z | p.m. 19 at work | at work | | N. | |
| | 21. I certify that (I) (this hospital) attended | | | to | 2, that (I) (we) last |
| | saw the deceased alive on 12-13 | 1967, and that | death occurred, atM, | from the causes and on the | ne date stated above. |
| | 22a. SIGNATURE | ~ 1 | | | ATE SIGNEO |
| | Hannet (1) | 45 , M.D | ATTENDING MEO. OIRECTOR | STAFF /2 | 122/1967 |
| | 22c. PHYSICIAN'S , | 1 | 22d. AODRESS / / | 11 | 20793 |
| | NAME (Type) / D (15 8 4 /- /- | 4) | 905 Shere | Can SV Her | donale |
| 23a | BURIAL, CREMATION, 230 OATE THEREOF 2 | 3c. NAME OF CEMETERY | OR CREMATORY 23d. | LOCATION (City, town of con | intyland (State) |
| 200 | REMOVAL (Specify) | Calab Hill | Cerellan C | 78a / P. 14 | M. M. |
| 0. | Bureal 26.190/ | easy ruce | - Valley Brown | accepted of the | O OLONATURE |
| 24 | FUNERAL OIRECTOR 1 254 Cal | track thee | REC'D BY RE | GISTRAR 25b. BEGISTRAR | S SIGNATURE |
| 81 | 15/6/12 11/0V/8/2 10 401. | 1 /1 2 | Y PRAIL PROPERTY OF THE | 1007 2011. 1. | 0 |
| | UICIDUU OU WUICIUS I. C. ELLUIZA | 101 100 107.1. | ZTOU DUALET | IND LARGERE | - 122 day |

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deseased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside corpargre limits, write RURAL and give negrest town) C.VLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) bapers, Page in 72 haurs a led Hrby d. NAME OF HOSPITAL OR INSTITUTION d. STREET ADDRESS e. IS RESIDENC in hospital, give street address ON A FARM ENAUE 121 NAME OF Middle DATE First Month remove carban and in any event, wit DECEASED OF Type or print) DEATH 6_COLOR OR RACE IF UNDER YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED AGE (In years last bashday) Months Days Hours WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work done 10b) KIND OF BUSINESS OR 1. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT COUNTRY ? physician a during most of working life, even if retired) NDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar removal, attending phys Henrich Stadler Bertha Eichenberger IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. NFORMANT Address permit. (Yes, no, ar which nown) (If yes give wor or dates of service) Len allen INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO as the stoting the underlying cause has been lost. use as WAS AUTOPSY PART II. OTHER-SIGNIFICANT CONDITIONS CONTRIBUTING-TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? CERTIFICATION State Dept. af Health NO TO FUNERAL DIRECTOR: After this certificate ā 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame: form. (City or town) (State) (County) Hour o.m. Not-While factory, street office bldg., etc. at work at wark pe 21. I certify that (1) (this haspital) attended the deceased fram sage 3 shauld to M, fram causes and an the date stated above. saw the deceased alive an 19 /2 and that death accurred at 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF M.D PHYS. DIRECTOR PHYS 22d 22c. PHYSICIAN'S ADDRES NAME (Type)

23c. NAME OF CEMETERY OR CREMATORY

Cemeteru

DATE

brion

23d. LOCATION (City or Town)

onnelsburg

(County)

REGISTRAR'S SIGNATURE

(State)

directar, page shauld be filed VR A15 (4) 20 M 1/66

23a. BURIAL, CREMATION.

Surial

REMOVAL (Specify)

23b. DATE THEREOF

an

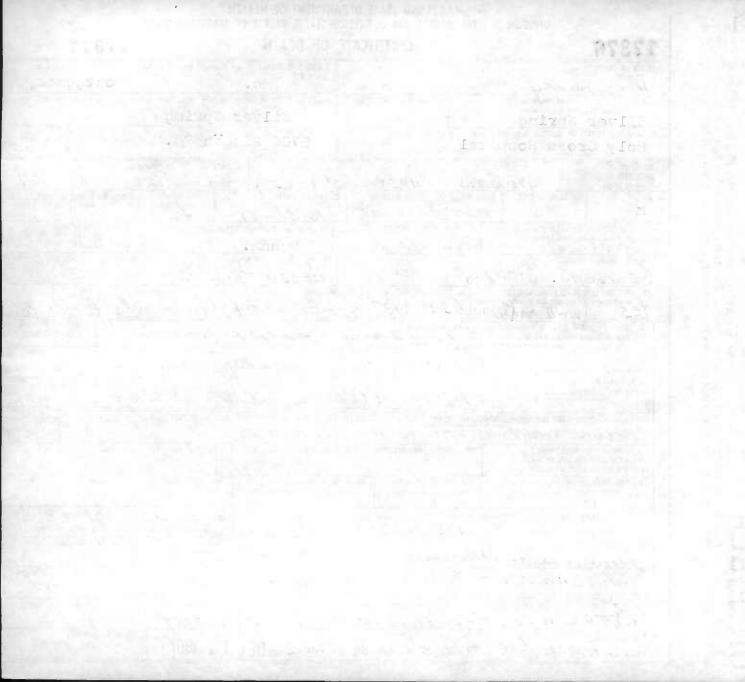
Inc.

17375 THE RESIDENCE AND A SERVICE OF

| | 1 4 3 4 9 | | CLKIIIIC | AIL | OI DEATH | | | 2101 | 1 |
|---|--|---------------------------------|------------------------|------------|--|--------------------|---------------------------|------------------|---|
| 1. | PLACE OF DEATH | | | | 2. USUAL RESIDENCE (W | here deceased | lived, if institution | n: Residence bef | are admissian) |
| | o. COUNTY | | ALCONIA A | | a. STATE Md. | | b. COUN | -14 | gomery |
| - | Montgom Eky b. CITY OR TOWN (If autside carporat | a limita | MARYLAN | | | .: 1 | limite conte DIID | | |
| | write RURAL and give negrest taw | /n) | C. LENGIH OF SIAT IN I | D | c. CITY OR TOWN (If aut | | | At and give near | est tawn) |
| | Silver Sprin | a a | | | | er Spi | | | -151 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | | | | d. STREET ADDRESS 9706 Pi | sgầh | Rd. | | e. IS RESIDENCE ON A FARM? YES NO V |
| 3. NAME OF First Middle | | | | | Last | 4. DATE | Month | n D | ay Year |
| | DECEASED (Type or print) | DEAN | (NMI) | -5 | TARKEY | OF DEATH | 12 | 3 | 1967 |
| _ | SEX 6. COLOR OR RA | | NEVER MARRIED | | DATE OF BIRTH | | AGE (In years | IF UNDER 1 YEAR | |
| 3. | M W | WIDOWED | DIVORCED [| | 10-31-2 | | last birthday) 46 yrs. | Manths Days | |
| 10a | . USUAL OCCUPATION (Give kind af wor | k dane 10b. K | ND OF BUSINESS OR | | 11. BIRTHPLACE (County 8 | State, ar forei | ign cauntry) | 12. CITIZEN | |
| dur | ing most of warking life, even if retired) | DE | OF. DEFENSE | | Penna. | | | COUNTRY | A. |
| 13. | FAIHER'S NAME | | | | 14. MOTHER'S MAIDEN N | | | | |
| | GEORGE B. S | TARKEY | | | HELEN F | HILLI | PS. | | |
| 15. | WAS DECEASED EVER IN U.S. ARMED FO | 1 . / 1 | SOCIAL SECURITY NO. | 17. IN | FORMANT | | Addres | SS | |
| (16 | es no, ar unknown) (If yes give war ar | A A DOC ALL | 3-18-2438 | ETER | Eniver 2 | 403 Co. | OL SPRING | - Kin As | FIPHI M. |
| H | 18. CAUSE OF DEATH (Enter only of | | | 1 600 PS | 1-0101110 Q | 70.) 00. | 2 A 11 100 | | NTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED B | Y: // // | RCULATUR | 11 | COLCAPS | F 15 | HOCK | | ONSET AND DEATH |
| | 4201 IMMEDIATE | | | / | | | | / | |
| | Canditians, if any, which gave | OUE TO COR | ONARY TH | 120, | MBOSIS-A | U/OCA | RDIAL W | EARCTEON | , 10-11 HOUR |
| ü | rise ta immediate cause (a), stoting the underlying cause last. | DUE TO A | OTTO VEC (| 20 | OTIC HE | ANT | | 10 - Cc | RCA E-6 YEARS |
| | | (c) | - 0 /- | | | | | | |
| 8 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? | | | | | | | | |
| SAT I | CHRONIC CHOLECYSTITIS WITH CHOLELIATIASIS YES NO | | | | | | YES NO | | |
| MEDICAL CERTIFICATION | 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER | Н | SCRIBE HOW INJURY OCCU | IRRED. (Ei | nter nature af injury in P | art I ar Part I | II af item 18.) | | |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Haut o.m. p.m. | Year 20d. 11 While at war | Nat While | | OF INJURY (Hame, farm, y, street, affice bldg., etc.) | 20f. | (City or town) | (County) | (State) |
| | 21. I certify that (I) (thi | | | ım | NOV. 19 | 66 to | 121 | 8 196) | that (I) (we) las |
| | saw the deceased alive | an /2 | 18 19 62, and | d that | death occurred at | 135 M | fram causes | and an the de | ate stated above |
| | 220 SIGNATURE | - 1 | | | 3 | A | | 22b. DATE SIG | |
| | Lawrence | D. mar | Car | M.D. | ATTENDING PHYS. | MED. DIRECTOR [| STAFF PHYS. | | |
| . 1 | | | | | 22d ADDRESS | | | SILVEI | R SPRING. |
| | NAME (Type) L FT W.R | CNICE D | | | 1111 SPR1 | NG 57 | REET | 3,000 | MD. |
| 230 | DEMONTAL (Comeils) | ATE THEREOF | 235 NAME OF CEMETER | | | 4.0 | ATION (City or Tov | vn) Kgur | nty) (State) |
| | 11 X | DEC. 1967 | GERMAN LUT | THERE | AN CEMETERY | VIAHA | 9NOY (i | TY PA. | |
| 24 | UNERAL DIRECTOR | 1 . 41/ | ADDRESS | | 2Sa. REC'D | BY REGISTRA | 1967 2Sb. RE | GISTRAR'S SIGNAT | URE |
| /(| · . In Di Livispan II | - OR IHAN GO | e. so's Aug Ili | 12 17 | 740 N | P 1 | 14h/ 3/ | MAN MAN | Manager, |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. of Health prior to burial, crematian, ar remaval, and in any event, within 72 hours after death-Page 4 may be retained by the haspital ar attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2 Film #G397 1/24/68 arcentificate OF DEATH death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY MONT GOMERS within 24 haurs after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town Al NeR / /SBP R/1/N/04 Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Health Care Center Middle RIANCHE DECEASED 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) Housewife 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alonzo M. L. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service Watson Andrews 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY CARCINOMA IMMEDIATE CAUSE (o) DUF TO

12. CITIZEN OF WHAT COUNTRY? Jennie (Maiden name unknown) INTERVAL BETWEEN ONSET AND DEATH YKNEWA Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? FEBRILE RESPIRATORY DISEASE NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. Not While , 19 62, table 21. I certify that (1) (this hospital) attended the deceased fram. 1967, and that death accurred at (2:40 PM, fram causes and an the date stated above saw the deceased alive an DEC 31 22b. DATE SIGNED 22o. SIGNATURE DEC 31, 1967 22d. ADDRESS 1015 SPRING SILVER SPRING.

23c. NAME OF CEMETERY OR CREMATORY

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed signed this certificate has been detached Page 4 may be retained by the FUNERAL DIRECTOR: After director, page should be filed VR A15 (4) 20 M 1/66

23o. BURIAL CREMATION.

Home. Arlington. Murphy Funera

23b. DATE THEREOF

Spring Grove (emetery 2So. REC'D BY REGISTRAR

DATEJAN

23d_ LOCATION (City or Town)

incinnati, Uhio

2Sb. REGISTRAR'S SIGNATURE

(County)

AGE (In years

lost birthday)

IF UNDER 1 YEAR

NO X

THE RESERVE OF THE RESERVE OF THE PROPERTY OF 6765 1 100

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | b. CITY OR TOWN (If autside corporate lin write RURAL end we gearest town) d. NAME OF HOSPITAL OR INSTITUTION (IF MONTGOMERY GENER NAME OF DECEASED (Type or print) SEX 6. COLOR OR RACE FEMALE USUAL OCCUPATION (Give kind of work doing most of working life even if retired) FATHER'S NAME ALBERT STEV WAS DECEASED EVER IN U.S. ARMED FORCE (If yes give wor or dote) WAS DECEASED EVER IN U.S. ARMED FORCE (If yes give wor or dote) IB. CAUSE OF DEATH (Enter only one PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE OF DEATH (If yes give wor or dote) Conditions, if any, which gave rise to immediate cause (a). Stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | CENTIFIC | MIL | OF DEATH | | | 1101 | .7 |
|----------------|--|---|----------------------------|------------------------------|-----------------------|--|----------------------|-------------------|------------------------|--|
| 1 | | | | MARYLA | | | 'LAND | b. COUNTY | MONTGO | MERY |
| 1 | b. CITY OR TOWN (I | f autside corporate limit give gearest tawn) | 5, | c. LENGTH OF STAY IN | 1b | c. CITY OR TOWN (If au | rtside carparate lin | | L and give near | est tawn) |
| | | | | | | d. STREET ADDRESS 6 WE | ST DEER | PARK D | RIVE | e IS RESIDENCE ON A FARM? YES NO |
| | | Fi B A | | Middle G I RL | | STEVENS | | Month ecember | | 19 67 |
| | | WHITE | 7. MARRIED WIDOWED | DIVORCED | | DATE OF BIRTH EC. 28, 196 | las. | | Months Days | |
| dur | ring most of working | (Give kind af wark dane lite, even if retired) VBORN | | ND OF BUSINESS OR IDUSTRY | | 11. BIRTHPLACE (County MONTGOMEF | | | 12. CITIZEN COUNTRY | |
| | 13. FATHER'S NAME ALBERT STEVENS | | | | 14. MOTHER'S MAIDEN I | | | | | |
| 1S. (Ye | es, no, pr unknown) | R IN U.S. ARMED FORCES? (If yes give wor or dotes o | f service) 16. | SOCIAL SECURITY NO. | | TOTAL RECOF | DS-MONT | Address GOMERY | | SP. |
| | PART I. DEAT Conditions, if any, nise to immediat stating the under | TH WAS CAUSED BY: IMMEDIATE CAUSE DUE which gave e cause (a), | (a) (b) | (a), (b), and (c) | to | In Jan | ene Desos | 3/2 | | NTERVAL BETWEEN INSET AND DEATH |
| ATION | PART II. OTHER SI | GNIFICANT CONDITIONS C | | TO DEATH BUT NOT RELATE | ED TO T | HE TERMINAL DISEASE CON | NDITION GIVEN IN | PART I(a) | 1' | 9. WAS AUTOPSY PERFORMED? YES NO |
| CERTIFICATION. | OR CONTRIBUTING | ☐ CAUSE OF DEATH | 20b. DE | SCRIBE HOW INJURY OCCU | JRRED. (| Enter nature af injury in | Part I ar Part II at | item 1B.) | · | |
| MEDICAL | 20c. TIME OF INJU Haur a.n p.n | 10 | 20d. II While at war | Nat While | | E OF INJURY (Hame, farm ry, street, affice bldg., etc.) | | y ar tawn) | (County) | (State) |
| | | ty that (1) (this has | pital) etten | ded the deceased fr | 6mA d that | death accurred at | 9 <u>5</u> /, ta | ım causes ar | , 19, i | that (I) (we) las ate, stated above |
| | 22a. SIGNATURE | 10 14 | Ai | Sor, | M.D | | MED. DIRECTOR | STAFF PHYS. | 22b. DATE SIG | 1/67 |
| | NAME (Type) | | | | | MEDICAL | CENTER | | | |
| | o. BURIAL, CREMATIC REMOVAL (Specify BUT 1 al | 12-30- | -67 | 23c. NAME OF CEMETE | | 4 | Gai | N (City or Town | ng Mo | ty) (Stote) |
| 24 | 4. FUNERAL DIRECTO | Erneste | Gooth | en garth | ers | DATE A | N 2 19 | 68 REGI | STRAR'S SIGNAT | Judge |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 yours offer death. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death.

Page 4 may be retained by the hospital or ottending physician.

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IN THE RESERVE OF THE RE

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| .000 | CERTIFICATE | OF DEATH | | 17386 | | | | |
|---|---|---|--|---|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery | MARYLAND | | Where deceosed lived, if institution: Virginia b. COUNTY | Residence before odmission) | | | | |
| b. CITY DR TOWN (If outside corporate limits, | c. LENGTH DF STAY IN 1b | c. CITY DR TOWN (II ou | tside carparate limits, write RURAL | ond give neorest town) | | | | |
| write RURAL and give negrest town) Be the sua (rural) | 4 days | Dunba | ar | 25.3 | | | | |
| d. NAME OF HOSPITAL DR INSTITUTION (If not in } | nospitol, give street oddress) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? | | | | |
| Naval Hospital | | 308½ 11th | Street | YES NO NO | | | | |
| 3. NAME OF First DECEASED (Type or print) Van | Middle Cleve STI | Lost LTNER | 4. DATE Month OF DEATH Decem | Doy Year aber 10 1967 | | | | |
| Male Caus | MARRIED NEVER MARRIED DIVDRCED DIVDRCED | 8. DATE OF BIRTH June 20, 1 | last hirthdoy\ M | UNDER 1 YEAR IF UNDER 24 HRS. In this Doys Hours Min. | | | | |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County | & Stote, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN I | NAME | | | | | |
| George Stiltner | | Grace Mor | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of serv | icel | INFORMANT Dunk | dar Address Address Stiltner, 308 | W. Va. 를 11th St. | | | | |
| 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: 18. CAUSE OF DEATH WAS CAUSED BY: 18. CAUSE (o) 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSE (o) 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: 19. CAUSE OF DEATH WAS CAUSED | r line for (o), (b), ond (i).) Encephalomalacia massive Hypertensive card | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| rise to immediate couse (a). stating the underlying couse DUE TO | | | | 19. WAS AUTOPSY PERFORMED? YES NO | | | | |
| 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CITY CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in | Port I or Port II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 | | ACE OF INJURY (Home, form tory, street, ollice bldg., etc.) | | (County) (Stote) | | | | |
| 21. I certify that (1) (this haspital saw the deceased alive an Dec | 21. I certify that ()) (this haspital) attended the deceased fram Dec. 6 , 19.67, ta Dec. 10 , 19.67, that ()) (we) last saw the deceased alive an Dec. 10 19.67, and that death accurred at 145PM, fram causes and an the date stated above. | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Charles S. Re | eves M. D. | 22d. ADDRESS | MED. STAFF PHYS. E | Dec.11, 1967 | | | | |
| 230. BURIAL (REMATION, REMOVAL/SPECILY) 23b. DATE THEREOF 12-13- | 23c. NAME OF CEMETERY OR Roselawn Ga: | CREMATORY . | 23d. LOCATION (City or Town) Princeton, W. | (County) (Stote) Virginia | | | | |
| 24. FUNERAL DIRECTORFALLS Church | 21/11/11/11/11 | | BY REGISTRAR 25b. REGIST | RAR'S SIGNATURE | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely filled in by the director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Bages shauld be filed with the State Dept. at Health prior ta burial, crematian, or remaval, and in any event, within 72 hours at VR A15 (4) 25M 1/67

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in toll the more districted to the second of the second of

smallerent from the

17380

CERTIFICATE OF DEATH

17381

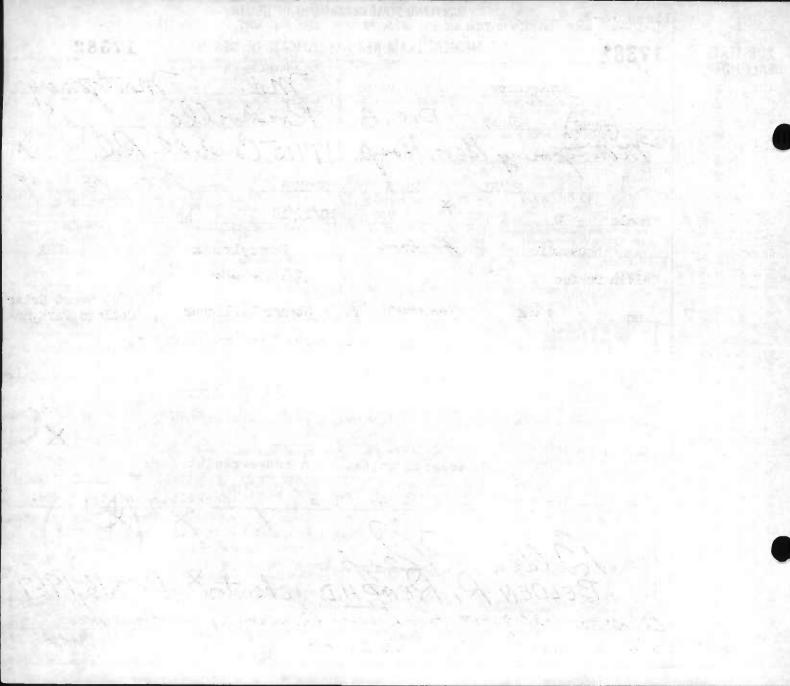
| 4 | | | CERTIFICATE | OF DEATH | 1.4 | 001 |
|---|---------------|---|------------------------------------|----------------------------------|--|--|
| | | LACE OF DEATH | | 2. USUAL RESIDENCE (Whe | ere deceosed lived, if institution: Residen | nce before odmission)/ |
| | 0 | COUNTY MANAGE | PA MARYLAND | o. STATE | St. OF Col b. COUNTY | molan Gen |
| ł | b | CITY OR TOWN (If outside corporate limits. | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside | corporote limits, write RURAL and giv | e neorest own) |
| ` | | write RURAL and give nearest town | 22 22 45 15 | Donk | 1011 Magnin | gran - 1 |
| ŀ | d | NAME OF UNSPITAL OF INSTITUTION IS AN IN THE | | d. STREET ADDRESS | OHE HINEK | on le. IS RESIDENCE |
| | a | NAME OF HOSPITAL OR INSTITUTION (If not in h | 11 + 1 | d. SIKEET ADDRESS / | Soy Lanier Place | ON A FARM? |
| ļ | | HOIG CRO | 53 Hospital | 4600- | Harlandike | YES NO |
| 1 | | AAME OF First | Middle | -10 Lost - 4 | A. DATE Month | Doy Year |
| | (| Type or print) — LENS | E. C. O | TINEME/2 | DEATH SECENDER | |
| 1 | S. S | EX 6. COLOR OR RACE 7. N | MARRIED NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years IF UNDER Months | 1 YEAR IF UNDER 24 HRS. Dovs Hours Min. |
| 1 | | FW | IDOWED DIVORCED | 11/aca 18,1 | 1889 78 yrs. | Doys Hours Mill. |
| 1 | 10o. | USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR | 11. BIRTHRUACE (County & S | | TIZEN OF WHAT |
| 1 | durir | ng most of working life, even if retired) Ref11RO-Pod, to 1 | INDUSTRY O. | 1/185hir | nation DC " | DUNTRY?/1.SA |
| t | 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAM | ME | V. J., . |
| 1 | | Samuel W. Stine | mpt 7 | Eliza bei | th Morgan | |
| ł | 15. | WAS DECEASED EVER IN U.S. ARMED FORCES? | | NFORMANT | Address | |
| 1 | | , no, or unknown) (If yes give wor or dates of serv | ice) | | | DINGUI |
| ł | | NO | | migni / i. Hiey | HNDER 1660 Lans | |
| 1 | | CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: | r line for (o), (b), ond (c).) | 11. +1. | 0 . | INTERVAL BETWEEN ONSET AND DEATH |
| 1 | | 1MMEDIATE CAUSE (a) | I neumonical Con | g react for | tur | |
| | | T L T DUE TO | 60 00 | | | - X-X-X |
| | | Conditions, if ony, which gove is to immediate couse (a), (b) | www | 1 | | |
| 1 | | stoting the underlying couse DUE TO | | | | |
| 1 | | last. (c) | | | | |
| | Z | PART II. OTHER SIGNIFICANT CONDITIONS CONTRI | BUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDI | TION GIVEN IN PART 1(o) | 19. WAS AUTOPSY PERFORMED? |
| 4 | ¥ ₩ | | | | | YES NO |
| | CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter noture of injury in Por | t I or Port II of item 18.) | |
| | | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| | MEDICAL | 20c. TIME OF INJURY Month, Doy, Yeor | 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, form, | 20f. (City or town) (Co | unty) (Stote) |
| 1 | MED | Hour o.m. | While Not While foct | ory, street, office bldg., etc.) | | |
| | 1 | pani, | ot work U ot work U | 1000 10 | 17 1 1/2 10 | 10 / Ab at 11\ 1 \ 1 |
| ı | | 21. I certify that (I) (this haspital | dirended the deceased from | double accurred at | A. ta Oce 14, 19 A. M. fram causes and an t | he date stated above |
| | - | saw the deceased alive an 220. SIGNATURE | 20.78 19.67, and ma | dealli accorred al | | ATE SIGNED |
| 1 | | ZZO. SIGNATORE | Bull | ATTENDING ME | ED. STAFF [] | 16,1967 |
| 1 | - | 22c. PHYSICIAN'S | Regalino M.I | 22d. ADDRESS / | RECTOR LI PHYS. LI WE | 6.10,10 |
| 1 | | NAME (Type) AUSSELL C | BUERLIND M.L | 1429 Un | unes at Blood W. | Ad. mg |
| 1 | 00 | | Too were or extressed on | COSHATORY | COLLICATION (C) | (6) |
| | 230. | BURIAL, CREMATION, REMOVAL (Specify) 12-19-196 | 23c. NAME OF CEMETERY OR | | 23d. LOCATION (City or Town) | (County) (Stote) |
| - | | | | | Washington, D.C | |
| | | FUNERAL DIRECTOR Joseph Gawler's Sons, | Inc. 5130 Wisc. | ye N. W BATE DE C | Y REGISTRAR 2Sb. REGISTRAR'S | |
| | 0 | Opelar against a agitte | THO . 7770 TOO | Y T ATO T RATE C | 7 1 TULY 1/1/10-0 | Fo. Section |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the State Dept. of Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours byter death. VR A15 (4) 25M 1/67

D. VOX. PRINTERS 2-124: - 100 N WITE 11 100 - 100 S Hely acess Hospital 4400 Hacken Fred -Stinemela Bunber 16, 67 May 16 1859 78 Weshington D.C. USB

MARYLAND STATE DEPARTMENT OF HEALTH



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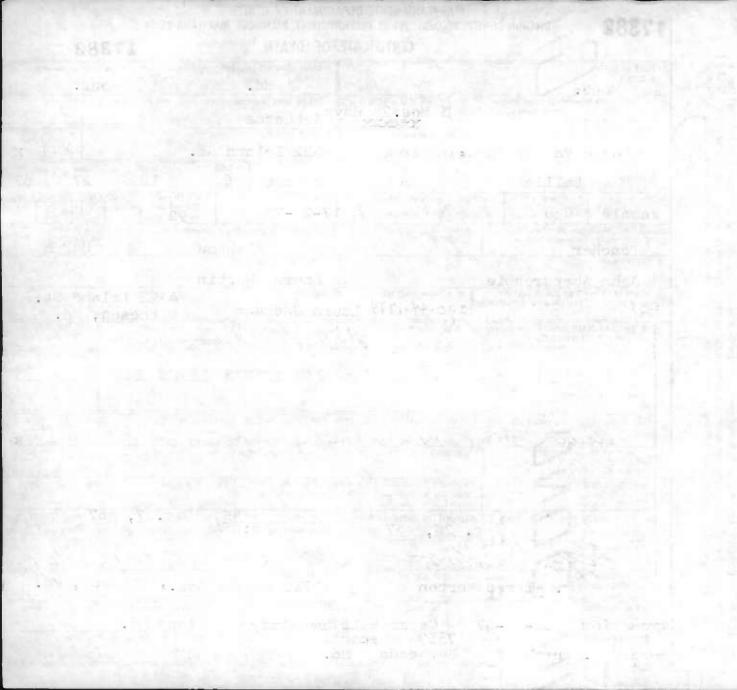
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17383

| | | | | | 7 1006 | , | | |
|---------------|---|-------------------------------|---|------------------------------------|-------------------|-------------------------|----------|--|
| 1. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| | Mont. | MARYLAND | a. STATE Md. | b. CDUN | Mont | | | |
| | b. CITY DR TDWN (If outside carparate limits, | c. LENGTH DF STAY IN 1b | | utside carporote limits, write RUR | | | | |
| L | write RURAL and give neorest town) Bethesda | 3 Mos. 28 day | Bethesda | 9. | | 51 | | |
| H | d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, or | nive street address) | d. STREET ADDRESS | | 1 | e. IS RESID | FNCE | |
| | Potomac Valley Nurse | | 4322 Lel | and St | | DN A FA | RM? | |
| 3 | NAME OF First | Middle | Lost | | | | | |
| 3 | DECEASED (Type or print) Lallie | A | Street | 4. DATE Month OF 12 | | , | 67 | |
| S. | SEX 6. CDLDR DR RACE 7. MARRIED | | B. DATE OF BIRTH | 9. AGE (In years | IF UNDER 1 YEAR | | | |
| | Female Cau WIDDWED | DIVDRCED _ | 12-27-75 | lost birthday) 92 yrs. | Months Days | Haurs | Min. | |
| 10 | | ND DF BUSINESS DR | 11. BIRTHPLACE (County | & State, ar fareign country) | 12. CITIZEN I | | | |
| a | Teacher | DUSTRY | A. | Labama | CDUNTRY | SA | | |
| 13 | 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN | | | - | | |
| | John Abergronbie | | Laura 1 | Martin | | | | |
| | S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. S | | NFORMANT | | s Lelan | d St | | |
| (| Yes, na, ar unknown) (If yes give war ar dates af service) 26 | 20-44-1774 Tian | ura Jacks | | esda. | | • | |
| - | 1B. CAUSE OF DEATH (Enter only one cause per line for | | ara bacter | sern Bern | | TERVAL BETY | WEEN | |
| | PART I. DEATH WAS CAUSED BY: | Carlie Fa | 70. | | | NSET AND D | | |
| | 422/ IMMEDIATE CAUSE (a) | carace fa | wire | | | | | |
| | Conditions if any which says > | 2500 . 000 | 2. A. a. | dia vascular o | 1 - | | | |
| | rise to immediate cause (o), | reno oca | crow Car | sup Vascular o | KAlen | | | |
| | storing the underlying cause | | | | | | | |
| | | TO DESTRUCTE AND THE TOP TO 1 | THE TERMINAL DISTACT CO. | UDITION ONES IN CASE IN | 110 | WAC ALITE | DCV | |
| 20 | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING T | D DEATH BUT NOT KETATED ID | THE TERMINAL DISEASE COT | NOTITION GIVEN IN PART I(a) | 13 |). WAS AUTD PERFORME | D.S | |
| ZAT | acule veral | | rotory in | Jerlion | | YES I | ND 1 | |
| CFRTIFICATION | | SCRIBE NOW INJURY DCCURRED. | (Enter nature of injury in | Part I ar Part II af item 18.) | | | | |
| MFDICAL | 20c. TIME DF INJURY Manth, Day, Year 20d. IN | | CE OF INJURY (Hame, form | | (Caunty) | (5 | Stote) | |
| MF | Hour a.m. While at wark | | ary, street, affice bldg., etc. | | | | | |
| | 21. I certify that (I) (this hospital) often | ded the deceased from | | 955 to Dec. 27 | 1967 | hat (I) (v | ve) lost | |
| ŀ | sow the deceased alive on Dec. | 26, 19 67, and that | death accurred 5 | : 05AM, fram causes of | and an the do | te stoted | obove. | |
| | 22a. SIGNATURE | | ATTEMPING | HED CTAFF | 22b. DATE SIG | NED / | | |
| | M.D. ATTENDING MED. STAFF DIRECTOR PHYS. D 12/27/67 | | | | | | | |
| | 22c PHYSICIAN'S 22d, ADDRESS | | | | | | | |
| | NAME (Type) Dr. Alfred Nor | cton | 7710 Dw: | ight Ave., Be | thesua | , PICL . | | |
| 23 | Ba. BURIAL, CREMATION, 23b. DATE THEREDF | 23c. NAME DF CEMETERY DR | CREMATDRY | 23d. LDCATIDN (City or Tav | vn) (Cauni | ry) (St | ote) | |
| C | remation 12-27-67 | Cedar Hill | Crematory | Suitland M | d. | | | |
| | 24. FUNERAL DIRECTOR | 7557ADDRESS'iscon | sin 2Sa. REC'I | | GISTRAR'S SIGNATI | JRE | | |
| R | | Rethesda M | | 0 00 4007 0 | Minute. | Quelas | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban pages P shauld be filed with the State Dept. af Health priar to burial, crematian, or remaval, and in any event, within 72 how Page 4 may be retained by the hospital ar attending physician. VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17384 CERTIFICATE OF DEATH 2b. HOUR 20. DATE OF DEATH Middle Lost 1. DECEASED-NAME First Month 23 Doy 1967 Year (Type or print) ures Ne S. DATE OF BIRTH 6. AGE (In years **IF UNDER 1 YEAR** IF UNDER 24 HRS. A RACE 3. SEX lost birthdoy) MONTHS HOURS requires that the death certificate be executed within 24 hours aft WHITE APRIL. 1864 emale 9. COUNTY OF DEATH 7b. CITIZEN OF WHAT COUNTRY? 7o. BIRTHPLACE (Stote or foreign 8. MARRIED NEVER MARRIED paper 4 country) U.S. WIDOWED X DIVORCED 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 10. CITY OR TOWN OF DEATH during most of working life, even if retired.) **INDUSTRY** give street oddress) BETHESDA lease remave carban event, 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13c. CITY OR TOWN 13d, INSIDE CITY LIMITS? 13e. STREET AND NUMBER 13b. COUNTY 4501 NO Washington in any Middle 1S. MOTHER'S MAIDEN NAME First Middle Last 14. FATHER'S NAME First GOLDEN UNKNOWN Address 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO 17. INFORMANT 4740 CONN. AVE. N.W. Yes, na, ar unknawn) PHILIP SURES crematian, ar remaval. APPROXIMATE INTERVAL 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: neeucone DUE TO, OR AS A CONSEQUENCE OF the Canditians, if ony, which gave) signed by the burial-transit rise to immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF stating the underlying couse by the haspital ar attending physician. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a) the TO FUNERAL DIRECTOR: After this certificate has been 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 19a, DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? CAUSES OF DEATH? YES 🗀 NO [use be detached far use State Dept. of Health 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 2, Item 18.) 21g. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Manth Day Year P.M. (If either, natify medical examiner) (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. State 21e. PLACE OF INJURY City or Town County 21d. INJURY OCCURRED While Nat while at wark 22o. I certify that (I) (this hospital) ottended the deceased from 12/22, 1967, ta 12/23, 1962, that (I) (we) last sow the deceased alive an 12/23 1962, and that in (my) (our) opinion death occurred on the dote and hour and from the O HOSPITAL OR ATTEND Page 4 may be retained director, page 3 shauld shauld be filed with the couses stated above, (I) (we) (did) (did not) view the body ofter deoth. 22b. SIGNATURE 22c. DATE SIGNED, DEGREE DIRECTOR PHYS. 22e. ADDRESS 22d. PHYSICIAN F.5505 NAME (Type) 23d. LOCATION (City or Jown) Fall's Church, V 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b, DATE 26/67 King David Mem. REMOVAL (Spicial)] Garden ADDRESS REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 30M REV. 1/68 DANZANSKY & SONS 3501 14th St. N. WATE

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17384 CERTIFICATE OF DEATH

17385

| | 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence | before odmission) |
|----|--|--|--|
| | o. COUNTY Montgumery MARYLAND | o. STATE Mary and b. COUNTY P | 1-ED |
| | b CITY OR TOWN (If outside corporate limits CLENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give | neorest town) |
| | write RURAL and give nearest town) | North Forcet ville | 16-2 |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE |
| 1 | Colonial Villa Nursing Home 212323 New Horngon | 3418 83 rd Ave. | ON A FARM? YES NO |
| | 3. NAME OF First Middle | apscott OF DEATH December | Doy Year |
| | (Type or print) dames E. | | 17, 1967 |
| | S. SEX Male 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH 7-16-1894 9. AGE (In years Inventory) 10st birthdoy) Months | YEAR IF UNDER 24 HRS. Doys Hours Min. |
| | 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZ | EN OF WHAT |
| | during most of working life, even if retired) O. C. Trans, 7 Operator BNOUSTRY river | Clark County Virginia (OU) | ITRY? U.S. |
| | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| | James E. Papscott | Henrietta Stickles | |
| | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 1 | NFORMANT 2/110 Address A A. | 0.0.1.0 |
| | (Yes, gg, or unknown) (If yes give wor or doles of service) 578-10- 6713 Ma | ary B. Japscott N. Forestville | Maryland |
| | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: | | ONSET AND DEATH |
| | 5020 IMMEDIATE CAUSE (o) DUE TO | emona 10 | -sauge |
| | Conditions, if ony, which gove) (b) Caronic la | a el to landa | 5000 |
| | rise to immediate couse (o), | the state of the s | 7 |
| | stating the underlying couse (c) | / 0 0 | 0 |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? |
| 7 | El Cerebral Certerioscheros | 45 | YES NO |
| | | (Enter noture of injury in Port I or Port II of item 18.) | |
| | I (IF CITTIER, NOTIFT MEDICAL EXAMINER) | | |
| | | CE OF INJURY (Home, form, ory, street, office bldg., etc.) 20f. (City or town) (Coun | ty) (Stote) |
| | Hour o.m. 19 While Not While of work of work | ory, street, office blugs, etc.) | |
| | 21. I certify that (I) (this-hospital) attended the deceased from | July , 1965, to 17 Dec, 196 | ? that (I) (we) last |
| | saw the deceased olive ap 12 / 14 19 62, and the | | |
| | 220. SIGNATURE William Starvey M. | D. ATTENDING MED. STAFF 22b. DAT | ESIGNED |
| | 22, DHYSICIAN'S | 22d. ADDRESS | 1000 |
| | NAME (Type) William Harvey | 2121 Peun, Cere Nu | / |
| ij | 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF COMETERY OR | | ounty) (Stote) |
| | | In Cemetery Prince Georges Co | . Md. |
| | 24. FUNERAL DIRECTOR Clark & Wison 8434 ADDRESS | Venue 250. REC'D BY REGISTRAR DES REGISTRAR'S SIG | NATURE Judge |
| 1 | arner E. Pumphrey, Inc. Silver Spring | | 0 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificote be executed within 24 hours after deoth Page 4 may be retained by the hospital or attending physicion. **TO FUNERAL DIRECTOR:** After this certificate hos been signed by the attending physician ond completely filled in by all director, page 3 should be detached for use os the buriol-tronsit permit. Then pleose remove corbon papers Page should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in ony event, within 72 hours of VR A15 (4) 20 M 1/66

The second of th A STATE OF So will be a second the contract of the contra

THE COUNTY OF THE PARTY OF THE

| 0 | | 1000 | CERTIFICATE | OF DEATH | | 17386 |
|---|-----------------------|--|------------------------------------|----------------------------------|--|--|
| | 1. F | PLACE OF DEATH | | 2. USUAL RESIDENCE (W | here deceosed lived, if institution: R | esidence before odmission) |
| | 15 | nontromeed | MARYLAND | O. STATE | b. COUNTY | 1. |
| 1 | b | CITY OR TOWN (If outside corporate limits. | C. LENGTH OF STAY IN 16 | c CITY ON TOWN (If out | side corporate limits, write RURAL of | |
| | 6 | write RARAL and give nearest town) | | P | | 15-1 |
| | 6 | ETHES da. I. NAME OF HOSPITAL OR INSTITUTION (If not in h | posnital dive street oddress) | d. STREET ADDRESS | / | L a IS RESIDENCE |
| | ~ | . Hame of hos the ok his honor (ii high iii hi | ospital, give street oddress) | d's | DI. | o. IS RESIDENCE ON A FARM? |
| 0 | 20 | burban Hospital | 0.10 | | suewor flace | YES NO L |
| | [| NAME OF First | Middle | Lost | 4. DATE Month | Doy Year |
| - | 5. 5 | Type or print) ////SVE d | M. | AVIOR | DEATH DIE. | JNDER 1 YEAR IF UNDER 24 HRS. |
| | 1 | 1 -1 | 보 | B. DATE OF BIRTH | | JNDER I YEAR IF UNDER 24 HRS. nths Doys Hours Min. |
| | 1 | 271000 100 41810 | IDOWED DIVORCED | 5-6-01 | 6 G yrs. | |
| | 10o. | USUAL OCCUPATION (Give kind of work done most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | | State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | | ng most of working life, even if retired) Housewife-Organist | | LowA | | U.S.A. |
| | 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN N | AME | |
| | | WILLIAM T. M. | PATT HIAS | FTH EL | Copplest | one |
| | 15. | WAS DECEASED EVER IN U.S. ARMED FORCES? s, no, or unknown) (If yes give wor or dotes of servi | 16. SOCIAL SECURITY NO. 17. I | NFORMANT | Address | |
| | | No | 578-62-5429 Re | 16. Dona | LA TRILOR - 1 | SON |
| | Ī | 1B. CAUSE OF DEATH (Enter only one couse per | r line for (o), (b), ond (c).) | 0 | 7 | INTERVAL BETWEEN |
| | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | METASTATIC | (ARCI | NOMA | GONSET AND DEATHS |
| | | 194 X DUE TO | | 1300000 | THEFT | |
| | | Conditions, if ony, which gove) (b) | CARCINOMA | 0F 7 | HYROID | SYEARS. |
| | | nise to immediate couse (o), Stoting the underlying couse | | _ | | |
| | | lost. (c) | | | | - W C - W |
| | _ | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIL | BUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE COND | OITION GIVEN IN PART 1(o) | 19. WAS AUTOPSY |
| 2 | MEDICAL CERTIFICATION | | NONE | 19-52 | | PERFORMED? YES NO |
| | S | 20o. ACCIDENT WAS UNDERLYING □ | 20b. DESCRIBE HOW INJURY OCCURRED. | | ort I or Port II of item 1B.) | 13 110 21 |
| 4 | E | OR CONTRIBUTING CAUSE OF DEATH NO | | | 0.7 1 0.7 10.7 11 0.7 10.7 | 12 14 15 15 15 15 |
| | B | (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor | 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, form, | 20f. (City or town) | (County) (Stote) |
| | MEDI | Hour o.m. | While Not While foct | ory, street, office bldg., etc.) | Zoi. (City of town) | (coom) (store) |
| | | p.m. 19 | OLMOIK - OLMOIK - | 840011 | 1/ 560 | 10/31 /11/11 |
| | -1 | 21. I certify that (I) (this hospital) saw the deceased alive an | aftended the deceased fram_ | TAKCH , 19 | 130 AM | 19 <u>67,</u> that (I) (**) last |
| | | 220. SIGNATURE | 1987, and mai | r death accurred al_ | | an the date stated above. 2b. DATE SIGNED |
| | | 220. SIGNATURE | elo III | | MED. STAFF | 12/27/67- |
| | | 22c. PHYSICIAN'S | M.C. M.C | 22d. ADDRESS | DIRECTOR L PHYS. L | 86 5 |
| | | NAME (Type) MADELOFA | EU MICHAEL | | Lder wood la | 4 - ma |
| | 23.0 | BURIAL CREMATION. 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR | 100 | 23d. LOCATION (City or Town) | (County) (Conta) |
| | 200. | BMOYAL(Sequity) 12/29/67 | Rock Creek | CKEMATUR! | Washington | (County) (Stote) |
| + | 24 | | | Dee 1250 PECID | | D. C. AR'S SIGNATURE |
| 1 | T | yson wheeler Funeral | Home Pools | lke 250. ktcb | N 2 1968 | iarles Judge |
| | | | MOCKVILLE, | marylandJA | IN WIND | |

Tunerol 3 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physicion and completely filled in by the fune part of director, page 3 should be detached for use as the burial-transit permit. Then please remove cashon dapers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. 24 haurs after death efely TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed Poge 4 moy be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67

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17386

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| 3- | | | | | | 1 4 126 | 3 / | | | |
|-----|---|--|-------------------------|---|--------------------------------|-----------------|-------------------|---------|--|--|
| | PLACE OF DEATH | | | | ere deceosed lived, if institu | | pefore odmission | n) 🗸 | | |
| | o. COUNTY IN | 110. | MARYLAND | o. STATE | b. COU | 7 7 | 0 | | | |
| H | b. CITY OR TOWN (If outside corporate | | LENGTH OF STAY IN 16 | MARY | de corporate limits, write RU | PRIN | | eges | | |
| 1 | write RURAL and give nearest tawn | 1) | 0 () | | de corporore ilmits, write ku | KAL ond give ne | Jorest town) | V | | |
| | | RK | 1 day 1/2 h | in Cliniton | / | | 76' | 2 | | |
| M | d. NAME OF HOSPITAL OR INSTITUTION | (If not in hospital, give | street oddress) | d. STREET ADDRESS | | | e. IS RESID | | | |
| 1 | WASH. SAN | + Hosp | 2 | 7458 | DAN JUAN | DR. | | NO 🔯 | | |
| 4 | 3. NAME OF T | First | Middle | Lost | 4. DATE Mon | th | Doy Year | r | | |
| | (Type or print) 05 | COH | Upton B | THOMPSON | DEATH /2 | | 10 196 | 07 | | |
| | S. SEX 6. COLOR OR RAC | E 7. MARRIED | NEVER MARRIED | 8. DATE OF MRTH | 9. AGE (In years | IF UNDER 1 YE | | V | | |
| | MALE White | WIDOWED | DIVORCED | 9-17-37 | lost birthday) 30 yrs. | Months Do | oys Hours | Min. | | |
| | 10o. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | done 10b. KIND (| OF BUSINESS OR | 11. BIRTHPLACE (County & S | | 12. CITIZE | N OF WHAT | | | |
| - | ENGINEER | Phile | o ropalory | MARYL | | 10.3 | 5. A. | | | |
| | 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NA | ME | | | | | |
| | Upton Inc | moson | | MIRIAM | DRURG | | | | | |
| | 15. WAS DECEASED EVER IN U.S. ARMED FOR | RCES? 16, SOCI | IAL SECURITY NO. 17 | 7. INFORMANT | Addr | ess | | | | |
| 1 | (Yes, no, or unknown) (If yes give wor or d | 10 (64 219 | -34-9257 | H P. | 12.24 | | | | | |
| F | 18/ CAUSE OF DEATH (Enter only or | | | 1105p. Ne | CORUS | | INTERVAL DET | METM | | |
| 1 | DADT I DEATH WAS CALISED DV | | | DELLET | | | ONSET AND DE | | | |
| | IMMEDIATE C | IMMEDIATE CAUSE (o) COPP R D) 17 C 77 R D) 17 R D) | | | | | | | | |
| 1 | 2001 | DUE TO | 1011-1 | 1000.10 | | | | | | |
| | Conditions, if ony, which gove rise to immediate couse (a), | (b) -4 16. | 11103 | ARCOMA | | | | | | |
| 1 | stating the underlying couse | DUE TO | 101111 | | | | | | | |
| | last. | (c) pan | - Cycop | e c v c ca | | | | | | |
| | PART II. OTHER SIGNIFICANT CONDITION | ONS CONTRIBUTING TO D | DEATH BUT NOT RELATED T | O THE TERMINAL DISEASE CONDI | TION GIVEN IN PART 1(o) | | 19. WAS AUTO | PSY | | |
| 1 | 200. ACCIDENT WAS UNDERLYING COR CONTRIBUTING CAUSE OF DEATH (IF FITHER NOTIFY MEDICAL EXAMINED) | | | | | | PERFORME YES N | D? | | |
| 1 | ₹ 20o. ACCIDENT WAS UNDERLYING □ | John December | DE HOW INHIDA OCCIDOR | D. (Enter noture of injury in Pa | et Los Dard II of item ID) | | 152 | 40 L | | |
| 5 4 | OR CONTRIBUTING CAUSE OF DEATH | | DE HOYY INJUKT OCCURRE | b. (chier holore of injury in Pa | n i or ran ii or item ib.) | | | | | |
| 1 | (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | - | | |
| 3 | 20c. TIME OF INJURY Month, Doy, Yo | | | PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) | 20f. (City or town) | (County | 1) (5 | Stote) | | |
| 1 | p.m. | 19 While of work | | octory, street, office bidg., etc.) | | | | | | |
| | 21. I certify that (1) (this | hospitol) ottended | the deceosed from. | . 19 | , to | . 19 | , thot (I) (w | ve) las | | |
| | saw the deceased alive a | | | nat deoth occurred at 💪 | M, from couses | and on the | date stated | above | | |
| 1 | 220. SIGNATURE | 0 | | | | 22b. DATE : | | | | |
| Т | Irady S | aden | head | | ED. STAFF RECTOR PHYS. | | | | | |
| П | 22c. PHYSICIAN'S | / | | 224 ADDDECC | / 6 | ILVERS | Diner | 44 | | |
| | NAME (Type) | | | 11200 Loc1 | (MOSI) WE. J | 17 A E 16 3 | 2 Luise C | ma | | |
| F | | TE THEREOF 2 | 23c. NAME OF CEMETERY C | OR CREMATORY . | 23d. LOCATION (City or To | own) (Co | unty) (St | tote) | | |
| 1 | BURIAL (Specify) | 13,1967 | ST. JOHNE CI | HURCH CEMETERY | HOLL YWOOD S | T MARY I | e Ma | | | |
| 1 | 24. FUNERAL DIRECTOR | | ADDRESS | 2So. REC'D B | RY REGISTRAR 2Sb. RI | EGISTRAR'S SIGN | ATURE | | | |
| 1 | W.CLARKE MATTINGLE | V LEONADO | TOWN MARYL | | C 1 5 1967 | | Pa . 'O | | | |
| | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haur Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon pepers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remayal, and in any event, within 72 hours after death. VR A15 (4) 25M 1/67

WIAM W. DADING.

עני. 13,1967 - מד. על מות לאינות מו ברוד מי הסטרישוסם, שד. ומתע שנים.

WILDCARRE JATTINGLEY LEGINARDTERM, MANYLANDS

E JAIAGE

CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY Montgomery o. COUNTY Montgomery MARYLAND 24 haurs after c. CITY OR JOWN (If outside corporate limits, write RURAL on Jaive nearestation) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest town) (D.C. 20016) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS etery-filled 5310 WRILEY YES NO NAME OF Middle Lost Year DECEASED 1967 OBIN DEC. event, (Type or print) ARDNER DEATH executed IF UNDER 24 HRS SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED remave COM lost birthdoy) Months any WHITE WIDOWED DIVORCED pup 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT .⊑ the death certificate be COUNTRY? physician c during most of working life, even if retired) INDUSTRY MICHIGAN burial, crematian, ar remaval, and Homemaker 13. FATHER'S NAME B. PHILLIPS HENRY ARDNER WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN (Yes, no orunknown) (If yes give wor or dotes of service) 081-01-6807 INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED BY: signed by the burial-transit LONSEL AND DEATH ATTENDING PHYSICIAN: The law requires that erebra Vascul attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse the State Dept. af Health priar ta has been OS WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) RTERIOSCLEROTIC NO be retained by the haspital or this certificate for 20o. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item IB.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year (City or town) foctory, street, office bldg., etc.) ot work TO FUNERAL DIRECTOR: After 1967 to DEC 21. I certify that ((1)) this haspital) attended the deceased fram. directar, page 3 shauld shauld be filed with the 1967, and that death accurred at 6:15 A.M. from causes and on the dote stoted obove. saw the deceased alive an It U G 220. SIGNATURE 22b. DATESIGNED M.D. PHYS. DIRECTOR 22c. PHYSICIAN'S **ADDRESS** O HOSPITAL NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Sion Episcopal Church Cem. Douglaston, L.I. N.Y. 23o. BURIAL, CREMATION DATE THEREOF 12/8/1967 ZULAPORESHOUNG CON WWW 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNFRAL DIRECTOR

1967

VR A15 (4) 25M 1/67

THE RESERVED TO STANFALLING A L. T. T. J. page migget a mate in the contract the contract that it is a visit

17388

FRIIFICATE OF DEATH

17389

| 1 | | CERTIFICATE | OF DEATH | | 11000 | |
|-----|--|-----------------------------|---------------------------------|-------------------------------------|--------------------------|--------------|
| # | 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (W) | here deceased lived, if institution | on: Residence before odm | issian) |
| 7 | o. COUNTY | | a. STATE | b. COUN | TY | |
| | Montgomery | MARYLAND | CITY OF TOWN 44 | | | |
| | b. CITY OR TOWN (If on side corporate limits, write RURAL and give negret town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (It outs | ide carparate limits, write RUR | AL and give nearest town | n) |
| | Takoma fark. | 25-days | District | of. Colun | ibia 4 | 173 |
| | d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give | e street address) | d. STREET ADDRESS | | e. IS R | RESIDENCE |
| | Machineton La Louis a | dhehtal | 1309 hoe | wit Rd n | 24 YES | A FARM? |
| 1 | 3. NAME OF First | Middle | | 4. DATE Month | | |
| | DECEASED 11 | | Last | Ar . | | Year |
| | (Type or print) I I a Tha t | rances | 1000 | DEATH December | | 19 67 |
| | S. SEX 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED 8 | . DATE OF BIRTH | 9. AGE (In years lost birthday) | Months Days Hou | NDER 24 HRS. |
| | F White WIDOWED | DIVORCED | 11-1-85 | 82 yrs. | Molitis Days not | MIII. |
| - 1 | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND | OF BUSINESS OR | 11. BIRTHPLACE (County & | State, or foreign country) | 12. CITIZEN OF WHA | T |
| 1 | during most of working life, even if retired INDU! | OU CATION | T-11 | | COUNTRY? | |
| - | Ketired School Teacher El | Duchin | 14. MOTHER'S MAIDEN NA | | 10,0, | |
| | 13. PATIER'S NAME | | 14. MOTHER 3 MAIDEN NA | · · | | |
| | Henry Kiggin | | Emila | Trice | | |
| | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SQC (Yes, na, ar unknown) (If yes give war ar dates of service) | CIAL SECURITY NO. 17. II | VFORMANT TO LIKE | Todd-Chester | reld. Misson | vis |
| | (11 yes gife wor or dates or service) | 9-42:7632 Wa | shington 5 | Initarium & | Hospital | Kerne |
| | 18. CAUSE OF DEATH (Enter only one cause per line for (a) | | 1 | | INTERVAL | RETWEEN |
| -1 | PART I. DEATH WAS CAUSED BY: | | Thomas | harie | ONSET AN | |
| | Immediate chose (a) | rebral | Incom | DOEIS | 180 | ay? |
| | DUE TO CO | rebro-s | scleros | 10 | 11/2/2/200 | 2011 |
| | Canditians, if any, which gave rise to immediate cause (a), | 1000 | / | *() > | under | unacp |
| | The state of the s | eumator | 7 0-1 | 1 -1 -1 | Mill | ~ |
| | lost. (c) | eu mon on | a ITT | nriris | 10 ge | a |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO | DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE COND | ITION GIVEN IN PART 1(a) | VIQ WAS | AUTOPSY |
| | 6 0 | | 1 | * | YES PERFO | ORMED? |
| | 5 Generalized H | | sclero | | IES _ | NO X |
| | 20b. DESCR | RIBE HOW INJURY OCCURRED. (| Enter nature of injury in Pa | off I or Port II of Item 18.) | | |
| | | | | | | |
| | | | E OF INJURY (Home, farm, | 20f. (City ar tawn) | (County) | (State) |
| | Hour a.m 19 While of work | Nat While at wark | ry, street, office bldg., etc.) | | | |
| | 21. I certify that (I) (this hospital) attended | | atr 1 19 | 5710. Dec 1 | 5. 19 6. Phat (1 | \ /wa\ last |
| | saw the deceased alive an CC 14 | 10 22 radopat | death accurred at | | and an the date sta | / \ / |
| 1 | 22a. SIGNATURE | 17 <u>07</u> , aur mui | deam accorred ut_ | m, num tuuses t | | irea abave. |
| - [| ZZO. SIGNATORE | 100 | | NED. STAFF | 22b. DATE SIGNED | 16/7 |
| | there to be | M.D | | IRECTOR L PHYS. L | Dec 15, | 10/ |
| / | NAME (Type) | 7-11 | 22d. ADDRESS | 5620Geo | rgia que | up. |
| | MAINTE LYHELDEOLGE - | - Dall | SILVE | r Spring | , med | |
| | | 23c. NAME OF CEMETERY OR (| REMATORY | 23d. LOCATION (City of Tow | n) (County) | (State) |
| | REMOVAL (Specify) 12/18/1967 | Parklawn C | emeteru | Rockville. | Maryland | |
| 1 | | ADDDCCC C . I | Tor prein | | GISTRAR'S SIGNATURE | |
| 1 | Varner & Pumphrey Inc. 8434 | | Md. DATHEC | 2 1 1967 20 | limber Jus | |
| - 1 | ULTURE C. PURTICAPUL 'INC. X4 14 | OILL IIIPVIME. | I Cha I DAILE LA | LI IUUII O | VA | / |

Pages 1 and 2 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician ond campletely filled to the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbar papers. Pages 1 and shauld be filed with the State Dept. at Health prior ta burial, crematian, ar remaval, and in any event, within the hours after debt. VR A15 (4) 25M 1/67

78511 Mont gower 4 Lakema Hickey 25 days Justinet of Columbia. Marchington Frencher of Hospital 1309 hourst Kel. 7:38 Mostly Frances lodd in some 15 White X 11-1-86 82 Rahad School Feeder In Strains Western Him Seators and Holy to There Heary Kinggin Cerebral Throw Dosis 18th Cerebro-sclerosis Undertakel Rheumatord Arthritis 10 games Generalized Arterio-sclerosis 189 5125 B 1 April 130 Ball Silver Springing for hamilton . Calley tempholic to the year metalog metalog and tempholic

7389

CERTIFICATE OF DEATH

17390

| | | | | | CEICITI | | OI DEAIN | | | 7. 1 | 031 | LF | |
|---------------|---|--|-----------------|--------------|----------------------|---|---|-------------|--------------------------|-------------|------------|-------------------------|---------|
| | PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE | Where dec | | | ence befor | re admissio | on) |
| 1 | o. COUNTY MONTGOMERY | | | MARYLA | ND | o. STATE MARINANCE b. COUNTY MONTGOMERO | | | | | / | | |
| | b. CITY OR TOWN (I | f autside corparate l | lighits, | | c. LENGTH OF STAY IN | | c. CITY OR TOWN (If & | utside carp | arate limits, write R | URAL and gi | | | |
| | SILVER | give nearest tawn) | | | Sylveryx. | | SILVER | e 51 | DRING | | / | 5,1 | |
| | | AL OR INSTITUTION (| If nat in has | spital, give | | | d. STREET ADDRESS | | 1 | | | e. IS RESII | DENCE |
| | Hohu | (POSS | Haca | toL | | | 12515 (| EDRS | DIA AUS | | | ON A F. | NO V |
| 3. | NAME OF | Cicoso | First | ,, ,,, | Middle | | Last | 1 4. DAT | | inth | Day | Ye | |
| | DECEASED (Type or print) | Jane | | | Frances | | Tothill | OF DEA | TH Dan | | 12 | | 67 |
| | SEX | 6. COLOR OR RACE | 7. MA | ARRIED T | NEVER MARRIED | | DATE OF DIDTH | 4/06 | 9. AGE (In years | IF UNDE | R I YEAR | IF UNDER | |
| I | emale | 10h.te | 100 | OOWED | DIVORCED | | CONCERNO CO | 4/00 | last birthdoy) | Months | Days | Hours | Min. |
| _ | | (Give kind af wark d | | | OF BUSINESS OR | | 11. BIRTHPLACE (County | & State, or | - | 1 12. 0 | ITIZEN OI | F WHAT | _ |
| | ng most of working | | 100 | INDU | | | | | | | OUNTRY? | • | |
| | FATHER'S NAME | TE | | OWY | r home | | District | | Tumpla | 10 | SA | | |
| | | iam Bean | | | | 30 | | | | | | | |
| 15 | WAS DECEASED EVE | DINITIC ADMED FOR | CES? | 16 500 | CIAL SECURITY NO. | 17 19 | Catherin | ener | 275 264- C 1 | tress | | 1 | |
| (Ye | s, no, or unknown) | (If yes give war ar da | ites of service | e) No | | | iel A. Joth | :11 | 5 5257 | Syco. | ring. | HHG, | |
| - | | | | | | tron | ier 11. Jorgi | u, | Jr. 1 W | leek | | | DATES |
| | | ATH (Enter only ane IH WAS CAUSED BY: | e cause per l | ine for (o) |), (b), and (c).) | Ter | mbolisDu | e To P | eritoni | tis | | ERVAL BET ISET AND D | |
| | 152 | IMMEDIATE CA | 102E (a) | | 1-00 | | | | 021100111 | | - | | - |
| | Conditions, if any, | The state of the s | DUE TO | Miilt | inlePeri | tor | ealAbsce | SSES | | | 100 | | |
| | rise ta immediat | e cause (a) | (n) | | | | | | | | | | |
| | stating the under | rlying cause | L. | Perf | oratedCa | rci | nomaOfSi | gmoi | dColon(| lWee | k) | | |
| | | CHILICANT CONDITION | (c) | UTING TO | DEATH BUT NOT BELAT | ED TO T | UE TERMINAL DISEASE CO | MDITION C | SINCEN IN DARK 1(-) | | 110 | WAS AUT | ODCV |
| ION | PART II. UTHER SI | GNIFICANT CONDITION | N2 CONTRIBE | UTING TO | DEATH BUT NOT KELAT | ו טו עז | HE TERMINAL DISEASE CO | INDITION G | SIVEN IN PART I(0) | | | PERFORM | ED? |
| CERTIFICATION | On ACCIDENTANA | - LINESON - F | | OOL DECCE | THE HOLL MILLEY OCC | IDDED / | | D 11 1 | 0 . 11 . () . () . () | | Y | 'ES 🔀 | NO [|
| RTIF | 20o. ACCIDENT WAS OR CONTRIBUTING | CAUSE OF DEATH | | 20b. DESCR | RIBE HOW INJURY OCC | URRED. (| Enter noture of injury in | Part I or I | Part II of item 18.) | | | | |
| | - | MEDICAL EXAMINER) | | | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJU | JRY Manth, Day, Yeo n. | Or | While - | JRY OCCURRED 2 | | E OF INJURY (Home, fari iry, street, affice bldg., etc | | f. (City or tawn) | (0 | ounty) | | (State) |
| Σ | p.r | n. | | at work L | at work | | | | | | | | |
| | | | | attende | d the deceased fr | | | 19.67 | , ta 12/ | | | not (I) (| |
| | saw the deceased alive on 12/11 1967, and that death occurred of 11:250, from causes and on the date stated above | | | | | | | | | | | | |
| | 22a. SIGNATURE | 1/ 1 | 1/2 | / | 1 Mars | | ATTENDING | MED. | STAFF | 22b. | DATE SIGN | VED / | - |
| | | Larol | 971 | W | ralle | M.D | . PHYS. | DIRECTOR | | 1/2 | 1/2 | -/6 | |
| | 22c. PHYSICTAN'S NAME (Type) | Harold | 5. 2 | idlas | | | 22d. ADDRESS 8402 Fent | ~ C1 | troot S: | 1.00 | Sunt. | N. N. | 11 |
| | | | | | | | | | treet. Si | | 1 | - | d |
| 23a | . BURIAL, CREMATIC REMOYAL (Specify | | | | | | REMATORY COMMEN | - | | | (Caunty | , | state) |
| | Surral. | Dec. | | 1967 | St. John | 1 90 | rest Glen | | rest Glei | n. Mar | ular | rd | |
| 24 | ALMERAL DIRECTO | 17 1 | (art | er84 | 34 Georgia | AU | 2Sa. REC | D BY REGI | | REGISTRAR'S | | | |
| W | Grner . | Pumphreu | I Tuc | - Si | luck Sprin | | I MARE! | 1 2 | 1967 | Charl | By 14 | CONTRACT. | |

Pages 1 and 2 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the fureral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbor papers. Pages 1 and 2 hours after death. Should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 22 hours after death. Poge 4 may be retained by the hospital or attending physician.

> VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

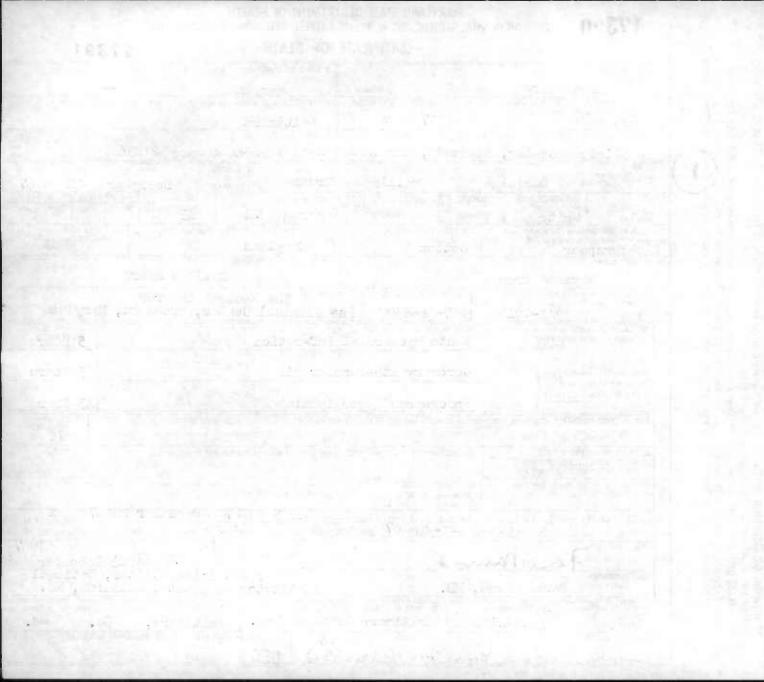
CERTIFICATE OF DEATH

1730

| | | | | | 3411777 | | | | | 210 | J .1 | | | |
|---|---|--|---|---------------|-----------------------------|--------|---|-------------|------------------------------------|---|-----------------|------------------|-----------------|--|
| | | PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) | | | | | | | |
| | | a. COUNTY Mon | ntgomery | | MARYLA | ND | o. STATE Mary] | land | b. COUN | | 10/1 | 0, | | |
| 8 | b | b. CITY OR TOWN (| f outside corporate limits, | 100 | c. LENGTH OF STAY IN | 1b | c. CITY OR TOWN (If ou | | orote limits, write RUR | AL ond give | neorest | town) | | |
| | 1 | Bethes | l give neorest town) da | | 17 days | | Baltimore | 9 | | | | 03 | 2 | |
| 1 | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | | | | | | d. STREET ADDRESS | | | | e. | IS RESID | ENCE | |
| 3 | T | he Clini | cal Center, | Bethe | sda, Maryla | nd | 5134 Alber | rta A | venue 21 | 236 | YE | ON A FA | NO X | |
| | | NAME OF DECEASED | First | | Middle | | Lost | 4. DATE | Mont | h | Doy | Yea | r | |
| | (| (Type or print) | Daniel | | Philip | | Trumpe | DEAT | | mber | 22 | | 67 | |
| | S. S | SEX | 6. COLOR OR RACE 7 | MARRIED] | NEVER MARRIED | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthdoy) | IF UNDER 1 Months | YEAR I | F UNDER Hours | 24 HRS. Min. | |
| 19 | | Male | White | WIDOWED | DIVORCED | | 6 March 1924 | | 43 yrs. | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 2073 | 110013 | mult. | |
| | | . USUAL OCCUPATION | (Give kind of work done life, even if retired) | | ND OF BUSINESS OR DUSTRY | | 11. BIRTHPLACE (County) | | foreign country) | 12. CIT | JATRY? | VHAT | | |
| | L | ithograp | her | Co | oustry tton | | Maryland | | | | | USA | | |
| | 13. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN N | | • 77 36 | | | | | |
| | | | aymond Trump | е | | | | | villa Mye | | - 50 | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Recorders | | | | | | | | | | SS | | | | |
| | 110 | Yes | 1942-1946 | 21 | 7-16-8500 | Th | e Clinical (| Cente | er, Bethes | da, M | aryl | and | | |
| | | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) | | | | | | | | | | INTERVAL BETWEEN | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Acute Myocardial Infarction | | | | | | | | | | 5 MSH AND DEATH | | | |
| | | 4201 | DUE TO | | | | | | | | | | | |
| | | (onditions, if ony, which gove nise to immediate couse (o), stating the underlying couse (DUE TO | | | | | | | | | 5 Years | | | |
| | | | | | | | | | | | | | | |
| | | lost. (c) Endogenous Hyperlipemia | | | | | | | | | | 43 Years | | |
| | Z | PART II. OTHER SI | GNIFICANT CONDITIONS CONT | RIBUTING T | O DEATH BUT NOT RELAT | ED TO | THE TERMINAL DISEASE CON | IDITION G | IVEN IN PART 1(o) | | 19. W | AS AUTO | PSY D? | |
| | SATIO | | | | | | | | | | YES | XX | NO 🔲 | |
| | CERTIFICATION | 2Do. ACCIDENT WAS | UNDERLYING CAUSE OF DEATH | 20b. DES | CRIBE HOW INJURY OCCI | JRRED. | (Enter noture of injury in I | Port 1 or P | Port II of item 18.) | | | | | |
| | 9 | | MEDICAL EXAMINER) | | | | | | | | | | 3 16 | |
| | MEDICAL | 20c. TIME OF INJU | JRY Month, Doy, Yeor | | | | CE OF INJURY (Home, form | | (City or town) | (Cou | nty) | (: | Stote) | |
| | W | p.r | n. 19 | While of work | | | ory, street, office bldg., etc.) | | | | | 3.5 | | |
| | | 21. I certi | fy that 🕱 (this hospit | al) attend | led the deceased fr | omD∈ | ecember 5 ,1 | 967 | to December | 2,490 | , tho | t (A) (v | we) lost | |
| | | saw the de | eceased alive on Dec | ember | 22 19 67, an | d that | deoth accurred at. | 4:45 | M, from couses | ond an th | e dote | | | |
| | | 220. SIGNATURE | 7) 1/4 | | 0 | | ATTENDING | MFD . | STAFF | | TE SIGNED | | 967 | |
| | | | terio M | ma | X | J.M | D. PHYS. | DIRECTOR | ☐ PHYS. 4 | | Decem | | | |
| | | 22c. PHYSICIAN'S NAME (Type) | Fonid Man | A MT | | | 22d. ADDRESS Th | e Cl | inical Cer | iter, | Nati | ona. | L | |
| | | | 20220 11020 | | | | | | Health, H | | ida, | ria . | | |
| | 230. | BURIAL, CREMATIC | ON, 23b. DATE THERE | | 23c. NAME OF CEMETE | | | | LOCATION (City or Tox | | (County) | , | tote) | |
| 2 | | REMOVAL (Specify | | .967 | 1 | | tional Cem. | - | altimore, | Co | • | M | d | |
| | 24. | FUNERAL DIRECTO | R | | ADDRESS | | 36 2So. REC'D | | 4.00 | GISTRAR'S SI | 6.0 | Late | | |
| | J | 0.00 | 7 . 0 | 11 | 7410 100 | (| D. I MEC | 97 | 146/1 | 1017 Car | 1 2000 | 2 | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any every, within 72 pages after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Poge 4 moy be retoined by the hospitol or ottending physicion.

VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17391 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF OFATH b. COUNTY a. COUNTY MONTGOMERY MARYLAND MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest town) write RURAL and give negrest town) HYATTSVILLE e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 14th CROSS HOSPITAL 8306 YES NO F AVENUE 3. NAME OF First Middle Last DATE Month Day Year DECEASEO MORTON UNTERMAN OFATH DECEMBER (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED OATE OF BIRTH last birthdoy) Manths Haurs MALE WIDOWED DIVORCED 15-1911 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) YORK SALESMAN 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ANNA SICKLICK ISAAC UNTERMAN 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 188th Street (Yes, no, or unknown) (If yes give wor or dotes of service) 111-09-9888 Diana Bengis New York, New York INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. OEATH WAS CAUSEO BY: ONSET, AND DEATH Cardiac arrest IMMEDIATE CAUSE (o) DUF TO Congestive heart failure. acute Canditions, if ony, which gove Hr. rise ta immediate cause (a), DUE TO stating the underlying couse Yrs. Arteriosclerotic cardio vascular disease last WAS AUTOPSY PERFORMEO? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO IC 20g. ACCIDENT WAS UNDERLYING 20b. OESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Ooy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or tawn) (County) (Stote) Hour a.m. foctory, street, office bldg., etc.) Not While 21. I certify that (1) (this haspital) attended the deceased fram. that (1) (we) last M, from causes and on the date stated above. saw the deceased alive an 190 and that death accurred at 10 22b. OATE SIGNEO 22a. SIGNATURE 12-13-67 PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) National Memorial Falls Church uria 12-17-1967 Park 24. FUNERAL OIRECTOR **ADDRESS** 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Goldberg Funeral Home 4217 9th Street N. DATE DEC

24 haurs after campletely filled in by the ave carban papers... Page y event, within 72 hays a remave carban ATTENDING PHYSICIAN: The law requires that the death certificate be executed and in any physician a burial, crematian, or remava permit. signed by the burial-transit **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. far use as the t Health priar ta b this certificate detached State Dept. O FUNERAL DIRECTOR: After pe director, page 3 shauld should be filed with the VR A15 (4)

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Security and the second second

offer death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbert pagers. Pages 1 and 2 shauld be filed with the State Dept. at Health priar to burial, crematian, ar removal, and in any event, within 70 haurs after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

Page 4 may be retained by the hospital ar attending physician.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

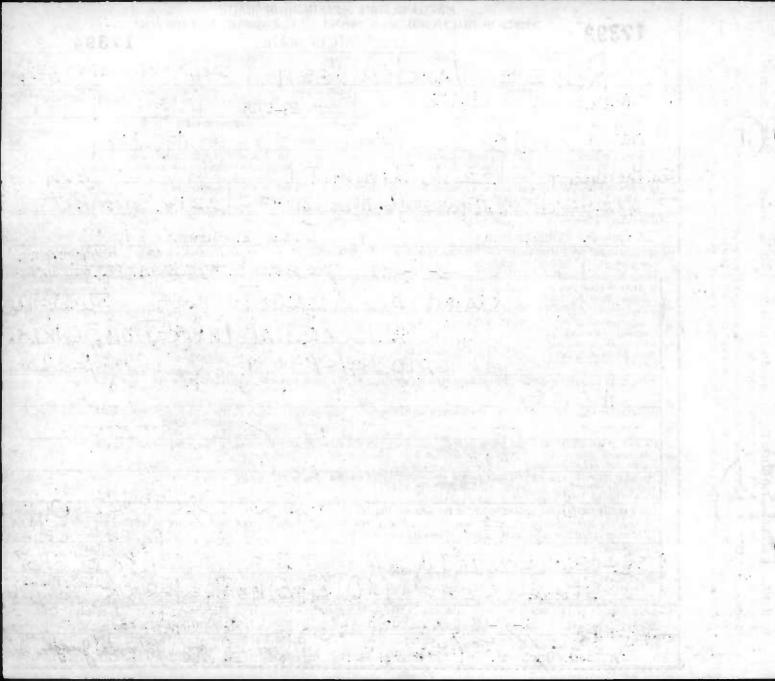
17393

| | | | CERTITIES | HE OF BEATH | | C - O D - / |
|---------------|--|--|--------------------------------|--------------------------------------|--|------------------------------------|
| | PLACE OF DEATH 7 | | | 2. USUAL RESIDENCE (WH | nere decrased lived, if institution b. COUNT | |
| | 1/2 | ontgomer | MARYLAND | | sund. | Montemery |
| | b. CITY OR TOWN (If outside write RURAL on give of | e corporate limits, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If ours | de carparote limits, write RURA | L and give pracest town |
| | Bel | hinda | 16 days | Bithu | ida. | 15,1 |
| | d. NAME OF HOSPITAL OR II | NSTITUTION (If nat in has | pital, give street address | d. STREET ADDRESS | | e. IS RESIDENCE |
| | | Ruh | usbeen Hageil | 1 870. | of Devenge | Mare yes NO |
| 3. | NAME OF DECEASED | First | Middle | Lost | 4. DATE Month | Luches 8 19 67 |
| 5. | (Type ar print) SEX 6. COL | OR OR RACE 7. MAI | RRIED NEVER MARRIED | 8. DATE OF BIRTH, 189 | DEATH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. |
| 17 | Perceles 115 | 12- | OWED X DIVORCED | 3/5/1808 | ast hemory) | Months Days Hours Min. |
| 100 | LUSUAL OCCUPATION (Give k | ind of work dane | 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & | | 12. CITIZEN OF WHAT |
| dur | n. USUAL OCCUPATION (Give k ring post of yorking life, ever | housewell | INDUSTRY | Marinter | , - DE | COUNTRY? |
| 13. | FATHER'S NAME | 1 1 1 | 1:11 | 14. MOTHER'S MAIDEN NA | AME | |
| | Lha | Mes of | ppece | Genvie | unknowi | a |
| 15. (Ye | . WAS DECEASED EVER IN U.S. es, no. or unknown) (If yes g | ARMED FORCES? ive warpor dates of service | 9 | 17. INFORMANT | Address | (d. 1+1 |
| | 160 | 110 | 213-48-2715,12 | Ins Much - | Man | (suggester) |
| | 18. CAUSE OF DEATH (Er PART 1. DEATH WAS | | far (a), (b), and (c).) | 101000000 | | ONSE AND DEATH |
| | | MMEDIATE CAUSE (a) | Thornwalner | Michigan | | 3 days |
| | 4201 | DUE TO | M a O. | | 0 | 2 2 11 |
| | Canditions, if any, which is rise to immediate cause | | Mychardia | Myara | | Luters |
| | stating the underlying c | | 2 | 0.11 1.0 | | 11-101 |
| | last. | (c) <u>C</u> | oronary b | uniso sell | source | YEAKS |
| 2 | PART II. OTHER SIGNIFICAL | NT CONDITIONS CONTRIBL | JTING TO DEATH BUT NOT RELATED | TO THE TERMINAL DISEASE COND | DITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? |
| 110 | | | | | | YES NO T |
| FIG | 20a. ACCIDENT WAS UNDER | IYING 🗆 I : | 20b. DESCRIBE HOW INJURY OCCUR | RED. (Enter nature of injury in Po | ort Lor Port II of item 18.) | |
| CERTIFICATION | OR CONTRIBUTING CAUS | E OF DEATH | | | | |
| | (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mo | | 20d. INJURY OCCURRED 20e. | PLACE OF INJURY (Hame, farm, | 20f. (City ar town) | (County) (State) |
| MEDICAL | Haur 'o.m. | | While Not While | factory, street, affice bldg., etc.) | 201. (City di Town) | (coomy) (sidile) |
| 2 | p.m. | | at work U at wark U | | 19 1 1 6 | |
| | | | attended the deceased fron | | | , 19 <u>67</u> , that (I) (we) las |
| | saw the decease | d alive an | 19 6 1, and | that death accurred of | fram causes a | nd on the date stated above |
| 1 | 22a SIGNATURE | ha.a | | ATTENDING | AFD. STAFF | 22b. DATE SIGNED |
| | sidney. | macan | ren | | IRECTOR L PHYS. L | 140/6/ |
| | 22c. PHYSICIAN'S NAME (Type) | Sidney J. M. | alawan | 8218 Wisc | annin Ann D. A | 2 2 2 |
| _ | <u> </u> | | | | | thesda, Maryland |
| 230 | o. BURIAL, CREMATION, | 23b. DATE THEREOF | 23c. NAME OF CEMETERY | | 23d. LOCATION (City or Tow | |
| | Buryal (Specify) | 12/11/67 | Ft. Lincoln | Mausoleum | Bladensburg | (P.G.Co) Md. |
| 24 | 4. FUNERAL DIRECTOR | | ADDRESS Wash | .D.C. 2Sa. REC'D | BY REGISTRAR 2Sb. REG | ISTRAR'S SIGNATURE |
| LTC | senh Gawler | s Sone 513 | O Wisconsin Av | | 1 - 1007 M | Lanto Outer |

TOTAL SECTION AND ADDRESS OF THE PARTY OF TH -and the last of the same TATE OF THE STATE transfer will be a fell of the second of the

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17393 CERTIFICATE OF DEATH 17394 20. DATE OF DEATH Middle 2b. HOUR DECEASED-NAME First ter death Doy 196 Year Dec Month 28 (Type or print) funeral IF UNDER 1 YEAR IF UNDER 24 HRS. 3. SEX 4 RACE S DATE OF BIRTH 6. AGE (In years lost birthday) Male he May 9. COUNTY OF DEATH 7o. BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED country) Holland WIDOWED DIVORCED | 12o. USUAL OCCUPATION (Kind of work done within 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12b. KIND OF BUSINESS OR 10. CITY OR TOWN OF DEATH law requires that the death certificate be executed within give street oddress during most of working life, even if retired.) INDUSTRY remave carban and in any event, 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13c, CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER YES NO Middle 14. FATHER'S NAME IS. MOTHER'S MAIDEN NAME First A. VanderVeen Rinze Mar tha K. Elhome please 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Gaithersburg Yes, no, or unknown) (If yes alve war or dates of service) Summit VanderVeen ar remaya 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO, OR AS A CONSEQUENCE OF Conditions, if ony, which gove: burial-transit rise to immediate couse (a), signed by DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) as the O FUNERAL DIRECTOR: After this certificate has been priar to 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 190. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20o. AUTOPSY? CAUSES OF DEATH? YES 🗔 NO F USe State Dept. af Health be retained by the haspital ar 21o. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) 21b. TIME OF INJURY far OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Doy Yeor P.M. (If either, notify medicol exominer) detached (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. Stote 21d. INJURY OCCURRED 21e. PLACE OF INJURY City or Town County While Not while at work O HOSPITAL OR ATTENDING 220. I certify that (1) (this hospital) attended the deceased from 2000 100 22, 1900, to 122 _1961, and that in(my) (our) opinian death occurred on the date and hour and from the saw the deceased alive an_ director, page 3 shauld shauld be filed with the causes stated obove (M) (we) (did))(did not) view the body after death 22b. SIGNATURE 22c. DATE SIGNED ATTENDING PHYS. DIRECTOR 22e. ADDRESS 22d. PHYSICIAN'S NAME (Type 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) (County) 23o. BURIAL, CREMATION 23b. DATE Lincoln Bladensburg. Md. REMOVAL (Specify) Ft REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR 2Sb. 24. FUNERAL DIRECTO 1968 30M REV Gaithersburg. Md.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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|-----|---|------|-------|-------|--------|----|
| | | CERT | IFICA | E (0) | DEATH | 1. |

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|--|--|-------------------------------|---------------------------------|-----------|---|--------------|--------------------------------------|---------------|-------------------|----------------------------|-----------------------|
| 1. PLACE OF DEATH o. COUNTY Montgo | | | MARYLAN | | O. STATE Dist/ of | ~ | eosed lived, if institu b. COL | | ence before | e odmissio | on) |
| b. CITY OR TOWN | (If outside corporate limits, and give nearest tawn) | | c. LENGTH OF STAY IN 18 | | CITY OR TOWN (IF of Washington | outside corp | orote limits, write RI | JRAL ond gi | ve neores | t town) | 3 |
| | PITAL OR INSTITUTION (If not in Hall Nursing | | e street address) | (| 4000 Mass | sachu | setts Ave | . N.W | | e. IS RESID ON A FA | DENCE ARM? NO X |
| 3. NAME OF DECEASED (Type or print) | First | | Middle E. VE | NCIL. | Lost | 4. DAT | H December | | Doy | Yeo | DI . |
| S. SEX Female | | MARRIED WIDOWED | NEVER MARRIED DIVORCED | | 6-1878 | | 9. AGE (In yeors last birthdoy) yrs. | | Doys Doys | IF UNDER Hours | Min. |
| 10a. USUAL OCCUPATION during most of working Housewi | ON (Give kind of work done ng life, even if retired) | | DF BUSINESS OR STRY | | 11. BIRTHPLACE (County Pe msylva | | foreign country) | | ITIZEN OF OUNTRY? | | |
| 13. FATHER'S NAME Louis C | ass Morris | | | 1 | 4. MDTHER'S MAIDEN Mary Ell | | evlin | | | | |
| 1S. WAS DECEASED E (Yes, no, or unknown | VER IN U.S. ARMED FORCES? (If yes give wor or dotes of se | | CIAL SECURITY NO. | | ormant evieve Ver | ncill. | Add - See Ite | | 2 | | |
| Conditions, if or rise to immediate uncolost. | derlying couse (c) DUE TO (c) | 6. | Enore/is | / a | Vescula Carol | n j | Thomas | bosis enal | ON | ERVAL BET SET AND D | DEATH |
| PART II. OTHER | SIGNIFICANT CONDITIONS CONT | RIBUTING TO | DEATH BUT NOT RELATED | D TO THE | TERMINAL DISEASE CO | ONDITION G | IVEN IN PART 1(o) | | | WAS AUTO PERFORMI ES | DPSY ED? |
| OR CONTRIBUTIN | YAS UNDERLYING □ IG □ CAUSE OF DEATH Y MEDICAL EXAMINER) | 20b. DESCR | None Month | RRED. (En | ter noture of injury in | Port I or I | Port II of item 18.) | | | | |
| 문 Hour'd | JURY Month, Doy, Yeor o.m. Dom. 19 | 20d. INJU While of work | Not While | | OF INJURY (Home, far street, office bldg., etc | | . (City or town) | (C | ounty) | (1 | State) |
| sew the | 21. I certify that ((1) (this haspital) attended the deceased fram | | | | | | | | | | |
| 22c. PHYSICIAN NOME (Typ | JOHN B | Un | HAU M | M.D. | PHYS. 22d ADDRESS S | DIRECTOR | M. Are | 2 (| hazi | des. | 50 |
| 230. BURIAL, CREMAT REMOVAL (Speci Remova. | ify) | 967 | 23c. NAME OF CEMETER Masonis Ce | | ry | Sil | LOCATION (City or T | | (County) | (5) | tote) |
| Joseph Gar | wler's Sons, | Inc. % | 2239004 | Ave. | NT W 250. REC | 'D BY REGI | STRAR 25b. R | EGISTRAR'S | SIGNATUR | Onde | .0 |

and 2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in 1971 funeral director, page 3 should be detoched for use as the burial-tronsit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours ofter death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 ho Poge 4 may be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17395 CERTIFICATE OF DEATH executed within 24 haurs after death. and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) ONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) Greenhelt 1 da SPRING d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE and completely filled in papers ON A FARM? NAME OF Middle 4. DATE Manth Year carban Ž OF DECEASED (Type or print) DEATH any event, SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1/YEAR IF UNDER 24 HRS NEVER MARRIED remove last birthday) Months Haurs WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done ATTENDING PHYSICIAN: The law requires that the death certificate be lease **INDUSTRY** COUNTRY? during most of working life, even if retired) physician 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, MIRALLES 16. SOCIAL SECURITY NO 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, as unknown) (If yes give war ar dates of service INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying cause be aetached far use as the State Dept, af Health priar ta has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (Stote) Hour a.m. factory, street, affice bldg., etc.) at wark at work 21. I certify that (1) (this haspital) attended the deceased fram should filed with the M, fram causes and an the date stated above 1947. and that death occurred at saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE STAFF ATTENDING M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S MON ES director, po 003 NAME (Type) 23b. DATE THEREOF 23a. BURIAL CREMATION. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) (County) BUTIAL (Specify) 12/23/67 Gate of Heaven Cem Silver Spring, Md. ADDRESS 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE. 24 FUNERAL DIRECTOR VR A15 20 M 1/ Tyson Wheeler Rockville, Md.

to particular district ALL THE REAL PROPERTY OF THE PARTY OF THE PA

17396 FOR STATE HEALTH DEPT. 1. PLACE OF DEATH defay 1, and 3 to Page Q. COUNTY MARYLAND b. CITY OR JOWN (If autside exparate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) sethes d. NAME OF HOSPITAL OR INSTUTUTION (If nat in haspital, give street address) form. Give Pages the certificate, writing the ward "pending" in pencil in Item 18. Give Pag 4 shauld be forwarded to the Chief Medical Examiner's Office along with NAME OF Middle DECEASED the (Type or print) 1010 with S. SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED event within 72 hours after death. WIDOWED DIVORCED pages land 2 10b. KIND OF BUSINESS OF 10a. USUAL OCCUPATION (Give kind of work dane during most of warking life, even if retired) INDUSTRY 40 ME 13. FATHER'S NAME E WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates of service 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (a) Coronary insufficiency, acute in any Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse 0 pup SD or remaval,

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) c. CITY OR JOWN (If autside carparate limits, write RURAL and give negres) rawn) d. STREET ADDRESS 3606 DUNDE e. IS RESIDENCE ON A FARMS NO P 4. DATE Manth Day Year 1960 DEATH YEAR AGE (In years IF UNDER last birthday) Haurs 12. CITIZEN OF WHAT SONSET AND DEATH years Coronary arteriosclerosis, severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PEREORMED? YES X 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) at wark 21. I certify that I took charge af the remains described above, held an Autapsy Inspection X and in my opinion death resulted fram: Natural causes Accident Suicide Homicide I Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, tawn, ar caunty) 23a. BURIAL, CREMATION, 23b. DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (State) LINCOLN 24. EUNERAL DIRECTOR

ONS 5130 WISCONSIN AUG DATE

5 may be retained far your O FUNERAL DIRECTOR: Page Health | VR A15ME 6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

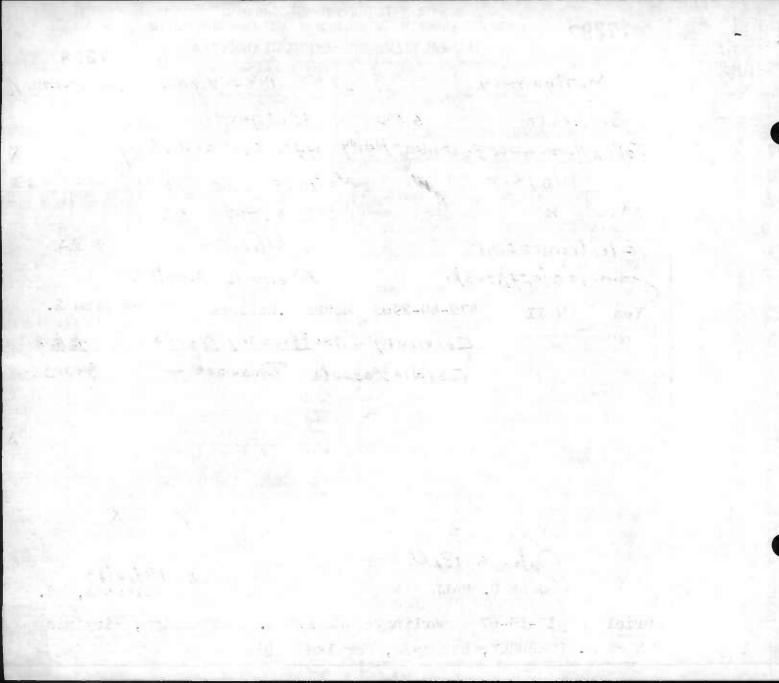
| . 1 | MEDICAL EXAMINER'S CERTIF | ICAIE OF DEATH | 398 |
|--------|---|---|-----------------------------------|
| Ī | 1. PLACE OF DEATH o. COUNTY Montgomery. 2. USUAL o. STAT | RESIDENCE (Where deceased lived, if institution: Resident E 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 | nce before admission) |
| | write BURAL and give nearest town) [3ethesa 2. 6 Mo. 1. | R TOWN (If autside corporate limits, write RURAL and give Bethesda- | e nearest tawn) |
| | ToPoz House 4400 Fost Wast Hopey 44 | 400 East West Hawy. | ON A FARM? YES NO |
| | | ce. OF Dec- | Day Year 10 19 67 |
| S | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF SeP: | - 3 1905 last birthday) Manths | Days Haurs Min. |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fig. 12 CT CD (CS. F.19) | HPLACE (State or fareign country) 12. Cl | TIZEN OF WHAT |
| | | Pers Maiden NAME 12/16/2. Mostinis. | |
| | Yes WW II 16. SOCIAL SECURITY NO. 17. INFORMANT Yes WW II 79-40-2905 Metta | Wife R.Wallace Same as I | tem 2. |
| | 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insuf | ficency. A eute- | INTERVAL BETWEEN ONSET AND DEATH |
| | Conditions, if any, which gave is to immediate cause (a), (b) Cardio Vascular | Drisease - | years. |
| | stoting the underlying couse (c) | | |
| MOITA | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA | IL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES NO |
| | 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | e af injury in Part I or Part II af item 1B.) | |
| MCDICA | 20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19 While at wark at work at work | | ounty) (State) |
| | 21. I certify that I taok charge af the remains described obove, held on Aut | topsy 🔲 , Inspection 🔀 , Inquiry 🖎 , | and in my apinian |
| | death resulted fram: Natural causes 🔼, Accident 🗌, Suicide 🔲, | Hamicide, Undetermined manner CHIEF MEDICAL EXAMINER | |
| | LACTUAL () V A CO OV | ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| - | L LAAMINER) | DEPUTY MEDICAL EXAMINER 4- 12/10/6 Address (Street, city, tawn, or county) Bethes | da, Md. |
| 2 | 230. BURIAL (REMATION, REMOVAL (Specify) Burial 23b. Date thereof 12-13-67 Arlington Natl. | 23d. LDCATION (City or Town) | (County) (State) |
| | 24. FUNERAL DIRECTOR ADDRESS | 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR S S | SIGNATURE |
| | ROBERT A. PUMPHREY, Bethesda, Maryland | DATDEC 15 1967 Jelian | es Judge |

VR A15ME (5) 6M 1/67

"pending"

necessary, please execute the certificate, writing the ward

TO DEPUTY MEDICAL EXAMINER:



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17393

CERTIFICATE OF DEATH

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| | | PLACE OF DEATH COUNTY MONT GOMERY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE ORDER O |
|---|---------------|---|--|
| | į | o. CITY OR TOWN (If outside carporate limits, | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) |
| | | REDCIEVILLE | ROCKVILLE 15.1 |
| | | d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| 0 | | 0401 GROSVENOR PLACE | 10401 GROSUENDRE / LARGE YES NO NO |
| | 1 | NAME OF First Middle DECEASED (Type or print) CUILLIANN CUI | Lost 4. DATE Manth Day Year OF DEATH 12 18 19 67 |
| | S. S | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED 4 | B. DATE OF BIRTH 9. AGE, (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 14-7-1907 60 yrs. Months Days Haurs Min. |
| | 10a. duri | USUAL OCCUPATION (Give kind af work dane ne-most of warking life, even if retired) OCLECTORS OF DEALER AND STATE OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT COUNTRY2 |
| | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | 1 | ISIDORE WEINBERG | HONA REISANIEC NFORMANT Address |
| | 15. | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I | NFORMANT Address |
| | {Ye | s, no, ar ynknown) (If yes give war ar dates of service) UNKNOWN MR | SBELLA WEINGERG SAME AS 2) |
| | | 18. CAUSE OF DEATH (Enter anly ane cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRODUCT OF DEATH (Enter anly ane cause per line for (o), (b), and (c).) | cerdial difarch Sustantial |
| | | Conditions, if ony, which gave) | |
| | | rise to immediate couse (o), | |
| | | stating the underlying couse (c) | |
| | N. | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| 1 | SIE | | YES NO 🔀 |
| | CERTIFICATION | 20g. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | (Enter nature af injury in Part I ar Part II of item 1B.) |
| | MEDICAL | | CE OF INJURY (Hame, farm, ary, street, affice bldg., etc.) 20f. (City or town) (County) (State) |
| | | 21. I certify that (I) (this hospital) attended the deceased from | t death occurred of SOMM, from cooses and on the date stated obave. |
| | | | |
| | | 22a. SIGNATURE Charles Charleson M.C. | |
| 1 | | 22 SHYSKIAN'S HERBERT ABRAMSON M. | D 1250 - Com Rue MW. Wash DC |
| | 230 | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CO. REMOVAL (Specify) 220-1967 DEW MONTETIC | CREMATORY 23d. LOCATION (City or Town) (County) (State) |
| | 24 | FUNERAL DIRECTOR ADDRESS | , 25g. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| | | OLDBERGEONERALITOME 42179745.N. | |

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the ottending physicion ond completely filled in by director, page 3 should be detached for use os the burial-tronsit permit. Then please remove carbon papers. P should be filed with the State Dept. of Heolth prior to burial, cremption, or remavol, and in any event, within 72 how VR A15 (4) 20 M 1/66

HERBERT HBRAMSON M.D. 1250 - Comm Clas KLO-World

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| 4 | 17 | 9. | 18 4 | 10 | |
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| - 12 | - 6 | 54 | 2.7 | 8.7 | |

| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) |
|---|--|
| O. COUNTY MARY MARY | LAND O. STATE VIRGINIA B. COUNTY ARLINGTON |
| b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY II | N 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| write RURAL and give nearest tawn) KENSINGTON 10-78-6 | 1 ARLINGTON, VIRGINIA 823 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE |
| Kensington Bardens Janite | run 231 N George Mason De VES NOX |
| 3. NAME OF First Middle | Lost 4. DATE Month Doy Year |
| DECEASED (Type or print) BERTHA T. | Whaley DEC. 14 1967 |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Female White WIDOWED DIVORCED | 1-25-1909 lost birthdoy) Months Days Haurs Min. |
| 10a. USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT |
| during most of warking life, even if revited) NOUSEWITE NOUSEWITE | 11. BIRTHPLACE (County & Stote, or foreign country) WASNINGTON 12. CITIZEN OF WHAT COUNTRY? COUNTRY? |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| CHARLES KAISER | CLARIA ANN DEITRICH |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Kensigs Ton Add. |
| (Yes, no, ar unknown) (If yes give wor or dotes of service) 557-03-774 | Makemeet M FEIVION 10225 Kens. PKWay |
| 18. CAUSE OF DEATH (Enter only one couse per line for (p), (b), opd (c).) | INTERVAL BETWEEN / |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RCPLES | ONSET AND DEATH |
| 1992 DUE TO A 1 | |
| Canditians, if any, which gave) (b) Anema | amat aspo |
| nse to immediate couse (a), stating the underlying cause DUE TO | |
| lost. (c) I reman | 11 Papac |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBITING TO DEATH BUT NOT REM | FED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY |
| NOL | PERFORMED? YES NO |
| 200. ACCIDENT WAS UNDERLYING \(\square\) 20b. DESCRIBE HOW INJURY OF | CCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) |
| ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | ccurrent notice of inforty in 1011 for 1011 in all near 10.7 |
| [IF EITHER, NOTIFY MEDICAL EXAMINER] 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) |
| Hour o.m. While NotWhile | foctory, street, office bldg., etc.) |
| p.m. 17 atwork LJ of wark LJ | A A A TOTAL |
| 21. I certify that (I) (this has prival) attended the deceased saw the deceased alive an angle 119 19 19 19 | fram Mo, 19 ta 12/14, 19 6, that (1) (we) last and that death occurred at 3 5 M, fram causes and an the date stated above. |
| 220. SIGNAFARE | PM, Indirectorses and an me date stated above. |
| habit I down do | ATTENDING MED STAFF DIRECTOR DIRECTOR DIPHYS. DI 2/14/8/ |
| 22c. PHYSICIAN'S | 22d. ADDRESS |
| NAME (TYPE) BERT , HIBADEA | U ROCKVILLE, MD. ZO852 |
| | TERY OR CREMATORY 7 23d. LOCATION (City or Jown) (County) (State) |
| BONDY 12-16-67 NATIONAL | MEMORIAL TORK FALLS LHURCH, A- |
| 24. FUNERAL DIRECTOR ADDRESS | WATS# . 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| FJ. COLLINS 3821-14th ST. N.W. | D.C. DATE DEC 18 1967 Octionly Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 bayrs of the contraction. Page 4 may be retained by the haspital ar attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban pape shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event within 7.

| | DIVISION OF VITA | MAKTLAND STA AL RECORDS, 301 W | | | | 21201 | | |
|--|---|---|---------------------|--------------------------|--------------------------------------|----------------|----------------------------|-----------------------------|
| 17400 | | • | FICATE OF | | | | 1740 | 1 |
| 1. DECEASED-NAME Fir (Type or print) FLOR | ENCE HE | Middle NDERSON | Last WH | FELER | a. DATE OF DEATH Month | 24 | Year | 2b. HOUR |
| 3. SEX Female | 4. RACE CAU | - | S. DATE OF BI | 31-1 | 8 18 6. AGE (1) last bird | | FUNDER JYEAR ONTHS DAYS | HOURS MIN. |
| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT CO | 9 , WIDON | | SCED [| OUNTY OF DEATH | | | M |
| 10. CITY OR TOWN OF DEATH WHEATEN | give street | VERSITY 1 | (If not in hospital | | f working life, even | if retired.) | 12b. KIND OF B INDUSTRY | USINESS OR |
| 130. USUAL RESIDENCE (Where dece admission) STATE MARYAA | pased lived, if institution: R | esidence before 13c. CIT NGCMERY. B | Y OR TOWN | YES NO | 13e. STREET AND | SPBN. | G LAKE | DR. |
| 14. FATHER'S NAME First | Middle | Last | IS. MOTHER'S MA | AIDEN NAME First Unknow | n | Middle | | Last |
| 160. WAS DECEASED EVER IN U.S. A | RMED FORCES? 16b. | SOCIAL SECURITY NO. | 17. INFORMANT NURS | ING 120 | TORDS | Address | | |
| 18. CAUSE OF DEATH (Enter PART I. DEATH WAS CAU IMME | anly one couse per line for SED BY: DIATE CAUSE (a) | (a), (b), and (c).) Mlume | mia | | | | | TE INTERVAL ET AND DEATH |
| Conditions, if ony, which gav | | ONSEQUENCE OF CONCEST | we He | ort | Foilur | ٤ | 1 | |
| stating the underlying cous | DUE TO, OR AS A C | hortic | · In | 0 - 1 | conce | | | |
| PART 2. OTHER SIGNIFICANT C | CONDITIONS CONTRIBUTING | TO DEATH BUT NOT RELAT | ED TO THE TERMINA | L DISEASE OR CONDI | ITION GIVEN IN PART | (0) | | |
| 19a. DATE OF OPERATION 19 | b. CONDITION FOR WHICH OF | PERATION WAS PERFORMED | 20a. AUTO | PSY? | 2Db. IF YES, WERE CAUSES OF DEATH | | SIDERED IN CER | TIFYING |
| 21a. ACCIDENT WAS UNDERLY OR CONTRIBUTING CAUSE OF D (If either, notify medical exam | EATH HOUR A.M. Mo | RY 21 | Ic. HOW INJURY OCC | URRED (Enter nat | ure of injury in Part | or Part 2, Ite | m 18.) | |
| ₹ 21d. INJURY OCCURRED 2 | I. PLACE OF INJURY (AT HO | ME, FARM, STREET, FACTORY.) 2 BUILDING, ETC. | If. LOCATION Street | et ar R.F.D. No. | City or Town | Tol | County | State |

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| sa | w the | deced | sed a | live a | n 10 | 2c : | 24, | 196 | 7, and the after dea | nat in (my) | (bur) | opinion | death o | curred | on th | e dote and hour | (I) (we |)) last m the |
|-----------|--------|-------|-------|--------|------|------|-----|-----|----------------------|-------------|-------|---------|---------|--------|-------|------------------|---------|-----------------------------|
| 22b. SIGN | IATURE | 1:// | 0% | 01 | 1 | 1/1 | 111 | 101 | 11.11 | ATTENDING | H | MED. | | STAFF | | 22c. DATE SIGNED | 167 |) |

22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS/ BER KRAMER 23a. Standoff REMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) Pr Geo Co Md.

32/28/67 23c NAME OF CEMETERY OR CREMATORY edan Hill (rematory. W.K. Huntemann & Son Funeral "ome 5/32 Georgia Ave N.W. 24. FUNERAL DIRECTOR

250. REC'D BY REGISTRAR DATE DEC 29 REGISTRAR'S SIGNATURE

(County)

(State)

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| | MAKILAND STATE DEPAKIMENT OF REALTH | |
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| DIVISION OF S | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, I | BALTIMORE 1, MARYLANI |
| 7401 | CERTIFICATE OF DEATH | 17402 |

| rem. | | |
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| 1 | A. COUNTY Montgomery Maryinan | a. STATE Maryland b. COUNTY Prince George |
| Y | b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) |
| | write RURAL and give pearest town) Silver Spring 17 months | Chillum 16.2. |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d/STREET ADDRESS e. IS RESIDENCE |
|) | Oak Haven Nursing Home | 625 Sheridan Street |
| | 3. NAME OF DECEASED (Type or print) CART DIA F COM | Last 4. DATE Month Day Year OF DEATH DEC 29 1067 |
| | Legit / (C) La Coras | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| | 7. MARRIED NEVER MARRIED | pril 26, 1883 State of the st |
| | 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR | Y 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | Retired House Cleaner District Govt. | Georgetown, DC USA |
| | 13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Unknown |
| | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, propr unkown) (Ifyesgivewarordatesofservice) 217-52-8293 Wal | NFORMANT lace F. Whelan-12717-Rigdate Ter. S. S. Md |
| | Conditions, if any, which gove rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO Att. Church however deterigrate | Interval Between ONSET AND DEATH ON INTERVAL BE |
| | | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ory, street, office bidg., etc.) |
| | 21. I certify that (I) (this hospital) attended the deceased from. | death occured a |
| | 22c. PHYSICIAN'S | ATTENDING MED. STAFF SIGNED |
| | NAME (STOP) S. WILLSAMS | 35 NEW YORK AUE NW. |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BUTLA1 | Washington, DC |
| | Varner E. Pumphrey, Inc. Silver Spring, Md | DATE JAN 9 1968 KURANES YMAN |

V207010100 silvar Spring 2 2 200 E Cas Haven Christian Chris 298), 35 A 26, 182 X lations Found Meanur District wow. . "Caurateman, DC 70 1 the . T. . St. was sandy the Parist - Indigent. T. About the Emph-te-the and the state of t description of the second STATE ASSESSMENT OF THE PROPERTY OF THE PARTY OF THE PART ac i de la companya d C. Class Contact Physics Contact Norman E. Bomperny, inc. Cliver Spring, W.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

c. LENGTH OF STAY IN 1b yr.5 mos

Middle

H.

NEVER MARRIED

DIVORCED

MARYLAND

7402

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton

University Nursing Home

6. COLOR OR RACE

White

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service)

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

John Hanson

Conditions, if ony, which gove rise to immediate couse (o),

stoting the underlying couse

20o. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER

Hour o.m.

20c. TIME OF INJURY Month, Doy, Year

21. I certify that (1) (this hespital)

deceased alive an

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)

DUE TO

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED

Helen

7. MARRIED

WIDOWED

X

10b. KIND OF BUSINESS OR INDUSTRY Retired

> 16. SOCIAL SECURITY NO. -1.2-5580A

20b. DESCRIBE HOW INJURY OCCURR

Not While

attended the deceased fram

20d. INJURY OCCURRED

1. PLACE OF DEATH o. COUNTY

NAME OF

S. SEX

CERTIFICATION

MEDICAL

DECEASED (Type or print)

Female

Secretary

CERTIFICA

| טונ | N SIKEEL, DALIIMI | JKE, MA | KILAN | D 21201 | | | | |
|--------|--|------------------|------------|------------------------|-------------|----------|--|-----------|
| TE | OF DEATH | | | | 174 | 03 | | |
| | 2. USUAL RESIDENCE (| Where dece | osed live | | | ce befor | e odmissio | n) |
| | o. STATE Maryl | | | b. COUN | Mont | tgom | | |
| | c. CITY OR TOWN (If ou | tside corpo | rote limi | ts, write RUR | RAL ond giv | e neores | t town) | |
| 3. | Bethe | sda | | | | / | 5,1 | |
| | d. STREET ADDRESS | | | | 305 | | e. IS RESID ON A FA | |
| | 4977 Batte | ry La | ane, | Apt. | KOXIXZ | | | NO 🗶 |
| | Lost | 4. DATE | | Mont | h | Doy | Yea | r |
| | White | OF DEAT | Н | Dec. | 16, | | 19 € | 57 |
| 8 | DATE OF BIRTH | | 9. AGE | (In years birthdoy) | IF UNDER | | IF UNDER | _ |
| | 11-27-1895 | | 7 | | Months | Doys | Hours | Min. |
| | 11. BIRTHPLACE (County | & Stote, or | | - | | TIZEN OF | | |
| | Property | Nam | 17 - b. I. | | US | UNTRY? | | |
| | 14. MOTHER'S MAIDEN I | VAME | ADIK | | I US | 18 | | |
| | Lizzie | Swens | 800 | | | | | |
| 7. IN | | sban | | Addre | | | | |
| T | incoln Wh | | | Sam | e as | It | em 2 | 2. |
| 7 | | | | | | | ERVAL BETY | |
| DE | ONCHOP | NEU | 1 MG | NIA | | | SET AND D | |
| -1 | | 150 | | 41.33 | | 1 | 1 | 4 |
| A | TRO PILY | | | | | 1 | 124 | RS |
| | | | | | | 1 1 | 1 110 | |
| VI | A.A | | | 1100 | | | 12 4/6 | 5, |
| TO TH | HE TERMINAL DISEASE COM | IDITION GI | VEN IN P | ART 1(o) | | 19. | WAS AUTO PERFORME | PSY D? |
| | | | | | | YI | parties and the same of the sa | NO W |
| ED. (1 | Enter noture of injury in | Port I or P | ort II of | item 18.) | | | | |
| | | | | | | | | |
| | E OF INJURY (Home, form ry, street, office bldg., etc.) | | (City | or town) | (Co | unty) | (9 | itote) |
| A/ | ov. 20 , 1 death occurred at | 944 123 A | to_D | EC 1 | , 19 on the | the date | at (I) (v | ve) los |
| | | | | | | ATE SIGN | | abavo |
| M.D. | ATTENDING PHYS. | MED. DIRECTOR | | STAFF PHYS. | DEC | | 196 | 7 |
| | 22d. ADDRESS 5 | 009 | Del | Rav | Ave | | | / |
| | | ethe | | | ryla | | | |
| OR C | REMATORY | 23d. | LOCATION | (City or Tov | vn) | (County) | (51 | ote) |
| | | 0.5 | | 0 | | 3.6 | | |

lease remave carban papers. Pages 1 and in any event, within 72 hours after O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the filled in signed by the attending physician and campletely burial-transit permit. Then please remave carban ar remaval, burial, crematian, be retained by the haspital or attending physician. with the State Dept. af Health prior ta TO FUNERAL DIRECTOR: After this certificate has been use as the be detached shauld director, page 3 VR A15 (4) 25M 1/67

23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial 24. FUNERAL DIRECTOR

220. SIGNATURE

PHYSICIAN'S

23b. DATE THEREOF 12-18-67

G.

ANGLE

23c. NAME OF CEMETERY Gate of
ADDRESS

20e.

Heaven Cem. |

Silver Spring, Maryland

ROBERT

PUMPHREY, Bethesda, Maryland

250. REC'D BY REGISTRAR DATE DEC 2 1

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STATE CENTERING LINE But I have been a restricted to the state of the state of

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married , attitue 2474 by 1 and 1 and 1 to post to At-BI-54 to It will Wester Little Line of the Control of

death.

7403

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17404

| - | | | | | | ~~~ | | | | | |
|-----------------|---|---|---------------------------|----------------------|-------------|--|------------------------|---------------------------------|-------------------|------------------------|--------------------------|
| 1. | PLACE OF DEATH O. COUNTY MON | tgomery | | MAR | YLAND | 2. USUAL RESIDENCE (No. STATE Vir | Where deceose | d lived, if institution b. COUN | | before odr | mission) |
| | b. CITY OR TOWN | (If autside corporate limit | s, | c. LENGTH OF STAY | IN 1b | c. CITY OR TOWN (If au | itside corparat | e limits, write RUR | AL ond give I | nearest tow | vn) |
| | Bethesd | a (rural) | | 29 day | rs | Annandale | | 18 | 8 | 3-3 | |
| | | TAL OR INSTITUTION (If no | at in haspital, | give street address) | | d. STREET ADDRESS | | 0.00 | | e. IS | RESIDENCE A FARM? |
| | Naval H | ospital | | | | 4509 Ola (| Columb: | ia Pike | | YES | □ NO 🔨 |
| | NAME OF DECEASED (Type or print) | Lloyd | rst L | Middle Franklin | | WHITE | 4. DATE OF DEATH | Decembe | er | Doy 31 | Year 19 67 |
| 5. : | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIE | | . DATE OF BIRTH | | AGE (In years lost birthdoy) | | | INDER 24 HRS. |
| M | ale | Cauc | WIDOWED | DIVORCE | D 🗌 A | lug. 2, 1900 | 6 | 61 yrs. | MOIIII3 | 0013 | 7013 Mill. |
| | | N (Give kind of work done life, even if retired) | | IND OF BUSINESS OR | | 11. BIRTHPLACE (County | & Stote, or fore | eign country) | | ZEN OF WHA | AT |
| uuii | ing illust of working | g me, even in termed) | | ADUSTK1 | | Johnson Co | ounty, | N.C. | | US | SA |
| 13. | FATHER'S NAME | | | | U218 | 14. MOTHER'S MAIDEN | NAME | | | | |
| | Thoma | s L. White | | | | Bessie G | uthrid | | | | 1 |
| | | ER IN U.S. ARMED FORCES? (If yes give wor or dotes | | SOCIAL SECURITY NO. | 17. 1 | NFORMANT | | Anna nde | le, Va | 1. | 6136 |
| Y | es | 1927 to 19 | 57 22 | 24-52-3231 | Mrs | s. Eleanor | White | 4509 010 | d Colu | umbia | Pike |
| | PART I. DE 5 7 6 Conditions, if on rise to immedic stoting the und lost. | re couse (o), erlying couse | (o) AC1 TO (b) TO (c) | ite Supurat | | Peritonitis | | | | | AND DEATH |
| CATION | PART II. OTHER S | SIGNIFICANT CONDITIONS (| ONTRIBUTING | TO DEATH BUT NOT REI | LATED TO T | HE TERMINAL DISEASE COI | NDITION GIVEN | N IN PART 1(o) | | 19. WAS PERF YES | AUTOPSY FORMED? NO |
| L CERTIFICATION | OR CONTRIBUTIN | AS UNDERLYING GCAUSE OF DEATH Y MEDICAL EXAMINER) | 20b. D | ESCRIBE HOW INJURY O | OCCURRED. (| Enter noture of injury in | Port 1 or Port | Il of item 18.) | | | |
| MEDICAL | Hour 'o | JURY Month, Doy, Yeor .m. 19 | 20d. 1 While of wor | | 20e. PLAC | E OF INJURY (Home, form pry, street, office bldg., etc. |) | (City or town) | (Coun | itγ) | (Stote) |
| | 21. I cert | ify that (1) (this has | pital) atten | ded the deceased | fram | | | Dec. 31 | | | (we) las |
| ч | | deceased alive an | Dec. 31 | 1967 | and that | death accurred at | 1155AM | , fram causes o | | | ated abave |
| | 220. SIGNATURA | 11/11/1 | Africa | | M.D | | MED. DIRECTOR | STAFF PHYS. | 22b. DAT 31 DE | | |
| 8 | 221. PHYSICIAN NAME (Typ | | x, M.I |). | | Naval H | | 1, Bethe | | Maryla | and |
| E | BURIAL, CREMAT REMOVAL (Specifical) | 101 | | | Memo: | rial Park | Arl | ATION (City or Tow ington, | | County) | (Stote) |
| | . FUNERAL DIRECT | | 1500 We | st Bradiac | ck Ro | ad 250. REC'I | D BY REGISTRA | | GISTRAR'S SIG | | m,d |
| E | verly-W | neatley | Alexar | dria, Virg | ginia | DATE | ar b | 4000 M | Menel | a. Ore | 2010 |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the haspitol or attending physician.

VR A15 (4) 25M 1/67

none was request their forces were covered to be sent no.

Settlemen (within) - and the days A STATE OF THE STA

Tellerolf Inval

Same 7 September 1

Commence of the contract of th

Johnson Commits,

Thousand In Thereto. A MANUTE OF THE PARTY sole green whe him to be a to the Committee This

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Total Total Total Time Cold Ac 11 10 - 145 . 191

W.D. Hills, M.D. This will be a second of the s

about 150 and the country of the cou

17404

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | | | | | CERTIFICATE | OF DEATH | | 174 | 05 |
|---|---------------|--|---|--------------------|--|--|--|----------------------|--|
| | | PLACE OF DEATH D. COUNTY | Montgome | ry | MARYLAND | 2. USUAL RESIDENCE (V | Where deceased lived, if institution ashington b. COUN | on: Residence be | |
| | t | | f outside carparate limits, aire negrest tawn) | | c. LENGTH OF STAY IN 16 3 months | 1 | tside carparate limits, write RUR, | AL and give ned | arest tawn) 47-3 |
| 0 | | | Valley Nu | | | d. STREET ADDRESS 4301 War: | ren St., N. | W. | e IS RESIDENCE ON A FARM? YES NO X |
| | [| NAME OF DECEASED (Type or print) | Agnes | | Middle Virgina W | illiams | 4. DATE Month OF DEATH DEC. | | Day Year O 19 67 |
| | S. S | emale | 6. COLOR OR RACE White | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED DIVORCED | B. DATE OF BIRTH Oct 18 | 9. AGE (In yeors last birthday) 81 yrs. | Manths Day | |
| | duri | ng most of working | (Give kind af wark dane life, even if retired) | | ND OF BUSINESS OR DUSTRY At Home | Frederic | & State, or fareign country) cksburg Va. | 12. CITIZEN COUNT | |
| | | | d Allen | | | | Henderson | /2n1 s | 10 2000 |
| | Ye. | s, no Necessed Eve | R IN U.S. ARMED FORCES? (If yes give war or dates of | | | rs Bertha | | | mgton, DC |
| | | PART I. DEAT | EATH (Enter anly one couse IH WAS CAUSED BY: IMMEDIATE CAUSE (c | | (a), (b), and (c).) Pulmon | ary El | lema | | ONSET AND DEATH |
| | | Conditions, if any | e cause (a) | o) | CONGEST | THE HE | ANT FAICH, | RE | WEEKS |
| | | last. |) (| c) | | CLENOTIC | | care | YEARS |
| 2 | CERTIFICATION | | GEA | 12 4 | O DEATH BUT NOT RELATED TO | LEROSIS | untul | A | 19. WAS AUTOPSY PERFORMED? YES NO |
| | | (IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) | 1 | SCRIBE HOW INJURY OCCURRED. | 7. | | | |
| | MEDICAL | Haur a.n p.r | n. 19 | While at work | Nat While of foct | CE OF INJURY (Hame, farm ory, street, affice bldg., etc.) | | (Caunty) | |
| | | saw the de | y that (I) (this hasp eceased alive an | ital) attend | led the deceased fram_ 29_1967, and tha | | 7 A M, fram causes of | and an the a | |
| | | 22a. SIGNATURE | Thales | Sec | varrez, M. | ATTENDING PHYS. | MED. STAFF DIRECTOR PHYS. | 22b. DATE S | 30/67 |
| 1 | 22- | 22c. PHYSICIAN'S NAME (Type) | CHILOCE | | AVARESE, M.S. 1 23c. NAME OF CEMETERY OR | 0. 11/25 | ROCKVILLO | | ROCKYKLE |
| | | BURIAL, CREMATIC |) | | Mt View Ba | ptist | 23d. LOCATION (City or Tow King Geor D BY REGISTRAR 25b. REC | , | unty) (Stote) |
| | 24. | Robert | RA Pumphre | У 75 | 557 Wisconsi | n Ave | | - ton 100 | a Control |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar aftending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and shauld be filed with the State Dept. of Health priar to burial, cremation, ar remaval, and in any event, within 72 haurs after deat

To the Security of the Property of the Security of the Securit T. BRANCH of the second of The page of the pa . W -rodata hota e A thorage and a representation of the second Polyson v Tourniss I as leading that the Company of the State of the S

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 4 | 27 | 9 | 0 | 2 |
|---|----|---|---|----|
| i | 7 | ¥ | U | 1) |

CERTIFICATE OF DEATH

17406

| PLACE OF DEA O. COUNTY | TH | | | | o. STATE | , | | lived, if institu | | nce before | odmission) |
|-----------------------------|---|--------------------|----------------------|------------|---|--------------|------------------|---------------------------------|--------------------|----------------------|--------------------------------|
| Montgon | nery | | MARY | | | | n, D. | | | | |
| b. CITY OR TOV | VN (If outside corporate limit L and give nearest town) | 5, | c. LENGTH OF STAY I | N 1b | c. CITY OR TO | WN (If ou | tside corporote | limits, write RU | JRAL ond giv | e neorest | town) |
| Wheaton | , | 3-41 | 2 days | | Washi | ingto | n, DC | | | | 473 |
| d. NAME OF HO | SPITAL OR INSTITUTION (If no | ot in hospitol, gi | ive street oddress) | | d. STREET ADI | DRESS | | | | е. | ON A FARM? |
| Univers | ity Nursino | Home | | | 5922 | 13t | h St | MII | | Y | ES NO |
| 3. NAME OF | Fi | rst | Middle | | Lost | | 4. DATE | Mor | oth | Dov | Year |
| DECEASED (Type or print) | | ie Fran | klin Willi | | 74-4- | | OF DEATH | | | 12/9 | 19 67 |
| S. SEX | 6. COLOR OR RACE | | NEVER MARRIED | | B. DATE OF BIRT | | | AGE (In years last birthdoy) | IF UNDER Months | 1 YEAR Doys | IF UNDER 24 HRS. Hours Min. |
| Male | White | WIDOWED | DIVORCED | , [] | /26/189 | | 200 | 73 yrs. | 1 10 (1 | TIZEN OF | MILLAY |
| | TION (Give kind of work done king life, even if retired) | | ND OF BUSINESS OR | | 11. BIRTHPLA | CE (County | & Stote, or fore | ign country) | | ITIZEN OF DUNTRY? | WHAI |
| Warehou | | p.c. | School D. | ist. | Phil | la. | Pa. | | | USA | |
| 13. FATHER'S NAM | AE . | | | | 14. MOTHER'S | 0 . | | | | | |
| Willian | Williams | | | | I da k | rrza | Lectu | ra | | | |
| 1S. WAS DECEASED | DEVER IN U.S. ARMED FORCES? | 16. S | OCIAL SECURITY NO. | 17. 1 | NFORMANT | | r | Addi | ress_/_ C | + | + N/111 |
| Yes | wn) (If yes give war or dotes | 19 | 7-09-4332 | Gos | trude U | 11:11: | GELA PIL | gahingt | sin a | nee | t, N.W. |
| | F DEATH (Enter only one cou | | | | | | A VY | Ten to Frida | 1071, | INTE | RVAL BETWEEN |
| | DEATH WAS CAUSED BY: | 0 | mahan | o m | 10.0 | 00 | 1100 5 | ma |) | ONS | SET AND DEATH |
| 162 | IMMEDIATE CAUSE | , , | 314240-9 | Pre | un C | | | 77770 | | 7 | |
| Conditions if | OUE ony, which gove | | + -+. | | | | | | | 12. | 1 |
| | diote couse (a) | (b) 0n | sec M | uo | age | ro | 149 | | | 0 | gravo |
| | inderlying couse DUE | | | | 200 | | | | | 1 | |
| last. |) | (c) | | | | | | | | 1 | |
| PART II. OTHE | R SIGNIFICANT CONDITIONS C | ONTRIBUTING TO | O DEATH BUT NOT REL | ATED TO T | THE TERMINAL D | ISEASE CON | IDITION GIVEN | IN PART 1(o) | | | WAS AUTOPSY PERFORMED? |
| A reciber | A WAS THE DESIGNATION OF THE | Look pec | COURS HOW IN HIRV OF | CCLIDACO | (************************************** | | D . 1 D . 1 | 1 () 10) | | yE: | S NO |
| OR CONTRIBU | T WAS UNDERLYING TING CAUSE OF DEATH OTIFY MEDICAL EXAMINER) | 205. DES | SCRIBE HOW INJURY OF | LCURRED. (| Enter noture of | injury in I | Port I or Port I | l of item 18.) | | | |
| ₹ 20c. TIME OF | INJURY Month, Day, Yeor | 20d. IN | JURY OCCURRED | | E OF INJURY (H | | | (City or town) | (Co | unty) | (Stote) |
| Hou | r o.m. | While of wark | Not While of work | focto | ory, street, office | bldg., etc.) | 0 16.1 | | | | |
| 21 1 0 | ertify that (1) (this has | | | fram | 12 | 7 1 | 0 67 10 | 12- | G 104 | 1-07 th | at (1) (wa) la |
| saw th | e deceased alive an_ | 2 - | | | | | | | | | e stated abave |
| 226. SIGNAT | URE | 1 | 0.6. | / | ATTENDING | 11 | MED. | STAFF - | 22b. D | DATE SIGNE | D |
| 1 16 | Uyron x | 1 SX | emple | M.E | PHYS. | E | DIRECTOR L | PHYS. |] 12 | 2-9 | -67 |
| 22c. PHYSIC | IAN'S | 0 | | | 22d. ADD | RESS | N-WL | | - | - | |
| NAME (| Type) Myron L | . Lenki | n | | 2309 | Shor | efield | Rd Wh | eaton | Md | |
| 230. BURIAL, CREA | MATION. 23b. DATE TH | FREOE | 23c. NAME OF CEME | TERY OR (| | | -6- | TION (City or To | | (County) | (Stote) |
| REMOVAL (Sp | fulling. | | | | | | | | | (40001114) | (51010) |
| Surjal DIR | Dec. 1 | 3, 1967 | ANDRESS | et (| emetery | 2So. REC'D | BY PECISTRA | rington | FERTDAD'S A | MATION ATION | and the |
| THE PROPERTY OF | rica . yle | n carte | 434 ADDRESS | ia Hu | enne | n- | C 13KA | 1967 25b. | The second | Carching | 0 |
| warner (| . Pumphrey. | Inc. S | ilver Snr | ina | Md. | DATE | LU | 11 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remaye carbon, papers—Pages 1 and 2 should be filled with the State Dept. at Health priar ta burial, cremation, ar remayal, and in any event, within 74 hours after death.

VR A15 (4) 20 M 1/66

17405 00111 .1.0 .materiales William Take and the second contains gothers the resulting which will be a like the best of the

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| K 21AIE | | MEDICAL EXAMINER 5 CERTIFICATE OF DEATH | 71401 | | | | | |
|--|---------------|--|---|--|--|--|--|--|
| TH DEPT. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| n PM3. Page | | o. COUNTY Montgomery MARYLAND O. STATE Maryland. | b. COUNTY : Mont gonzers/ | | | | | |
| ment . rd | | b. CITY OR TOWN (If outside corporate limits, LENGTH OF STAY IN 1b CITY OR TOWN (If autside corporate limits, | write RURAL and give nearest tawn) | | | | | |
| lep uttmer | | write RURAL and give nearest town) Cabin John | 7. 15 / | | | | | |
| Depart | | d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? | | | | | |
| ate D | | 25 Carver Rd. 25 Carver - | YES NO X | | | | | |
| I the | 3. | NAME OF First Middle Last 4. DATE OF DECEASED (Type or print) V.1791012 E. WILLIAMS. DEATH | Dec- 19 1967 | | | | | |
| The same of the sa | S. | SEX COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost bin Sept. 16, 1916 9. AGE (In lost bin 5) | | | | | | |
| fter deoth | 1Do dur | . USUAL OCCUPATION (Give kind of work done in grant of working life, even if retired) Charwoman 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or fareign country) Montvale, Virginia | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| nours afte | | FATHER'S NAME Allen Curtis 14. MOTHER'S MAIDEN NAME Mary A. Carter | | | | | | |
| rronsir permir. File pages 1 ond 2 v event within 72 hours after deoth | 15. (Ye | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Charles E. William. | Address 25 Carver Rd. | | | | | |
| wit | | 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) | INTERVAL BETWEEN | | | | | |
| burial-tronsit n ony event | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction, bilateral | 5 ONSET AND DEATH | | | | | |
| | | DUE TO | | | | | | |
| in ony | | Conditions, if any, which gave his to immediate cause (a). | | | | | | |
| ond in | | lost. ODUE TO | | | | | | |
| | ATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR | 19. WAS AUTOPSY PERFORMED? YES NO | | | | | |
|), or rer | CERTIFICATION | 20a EXTERNAL CAUSE WAS PRIMARY OCCURRED. (Enter nature of injury in Part I or Part II of ite CAUSE OF DEATH. | m 18.) | | | | | |
| cremation, or removal, | MEDICAL | 2Dc. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m. 19 2Dd. INJURY OCCURRED While Nat While at work at work | tawn) (Caunty) (State) | | | | | |
| | | 21. I certify that I taak charge af the remains described abave, held an Autopsy 💢 , Inspection 💢 , | Inquiry X, and in my apinio | | | | | |
| burial, | | death resulted fram: Natural causes 📉 Accident 🔲, Suicide 🔲, Hamicide 🔲, Undeterm | nined manner | | | | | |
| prior to b | | ACTUAL OF BOROR CHIEF MEDICAL EXAMINER | AA DATE COME | | | | | |
| ō | | SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER L | 22. DATE SIGNE | | | | | |
| 2 | | EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) | 12/20/67. | | | | | |
| Health | 230 | D. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (REMOVAL (Specify) 23d. LOCATION (| City or Town) (County) (State) | | | | | |
| | | Burial 12/23/67 Montva | | | | | | |
| (5) | 3 | ADDRESS WAS 250. REC'D BY REGISTRAR | 2Sb. REGISTRAR'S SIGNATURE | | | | | |

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funeral the h papers. (Fag completel within carbon and event, physician гетоме please = ding aftend Then the permit. physician. þ 0 signed cremation, burial-transit attending peen has the certificate hospital as 0 use prior detached for the this þ After CTOR: pe pluods FUNERAL ector, 0

> VR A15 (4) 15M 9/60

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CERTIFICATION

MEDICAL

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7408 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decaased lived, If Institution: Residence before admission) a. COUNTY e. STATE b. COUNTY MARYLAND Montgomery b. CITY OR TOWN (if outside corporete limits, Maryland Maryland Montgomery c. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL end give neerest town) Silver Spring Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Thaver Avenue Thayer Avenue NAME OF DATE Middle Month DECEASED OF EMMA KATE WILT DEATH 12 (Typa or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH AGE (In yeers | IF UNDER 1 YEAR last birthday) Months Dave Female Caucasian 84 WIDOWED TO DIVORCED 10a, USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Housewife Pennsylvania IISA Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME E. M. Abraham Katherine Yauger 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service) No Mrs. Ruth Holland Same as #2 above 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), end (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO DUE TO

e. IS RESIDENCE ON A FARM?

YES NO K

Year

196

IF UNDER 24 HRS.

AAin

Hours

27

INTERVAL BETWEEN active Myscardial Infantion ONSET AND DEATH unned Conditions, if eny, which geve rise to immediate causa (a), steting the underlying ceuse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6)) 19. WAS AUTOPSY PERFORMED? NO I 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm. (County) (Stete) 20c. TIME OF INJURY 20f. (City or town) Month, Dey, Yeer factory, street, office bldg., etc.) While Not While Hour a.m. et work af work 21. I certify that (I) (this hospital) attended the deceased from...... saw the deceased alive on. Dec 26 19 7.4M, and that death occured at from the causes and on the date stated above. 22b. DATE 22e. SIGNATURE ATTENDING SIGNED STAFF DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) Sylvan Heights Cemetery Buria /30/67 Uniontown, Pennsylvania 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIG 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Gawler's Sons, Inc., Washington, D. C.

Will Park the second since the since The state of the s There I want to the street of the street of the state of the street of t Proceedings of Long. Con. T. March Street, L. N. 1983 T. 1983 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 1 | 1-1 | 7 | 0 | 0 |
|---|-----|----|---|----|
| | 4 | 10 | U | 73 |
| | - | - | 4 | |

CERTIFICATE OF DEATH

| | | 174 | 0.9 |
|---------------|--|---|---|
| 1 | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence | e before odmission) |
| | a. COUNTY MONTGOMERY MARYLAND | O. STATE DISTRICT of Colombia | |
| 1 | b. CITY OR TOWN (If autside carpatate limits, C. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If autside carparate limits, write RURAL and give | nearest tawn) |
| 1 | write PURAL and give neorest town) | 11)956 - 0T6 , A | 1177 |
| 1 | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | d. STREET ADDRESS | e. IS RESIDENCE |
| | | MGN 4-1/TI. ST. 11.) | e. IS RESIDENCE ON A FARM? YES NO |
| - | NAME OF First Middle | 1707 1614 211 N.W. | |
| 13 | DECEASED | Last 4. DATE Month OF | Day Year |
| 1 | | | YEAR LIF UNDER 24 HRS. |
| 1, | | B. DATE OF BIRTH 9. AGE (In years FUNDER Norths Months | Days Haurs Min. |
| L | WIDOWED DIVORCED . | JEP1. 30, 1898 69 yrs. | TEN OF WHAT |
| | Da. USUAL OCCUPATION (Give kind of work done uring mast of warking life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | (0) | IZEN OF WHAT JNTRY? |
| | Retired-Federal employee | NEW YORK | CLAH. |
| 1 | 3. FATHER'S NAME | 14. MOTHER'S MAÍDEN NAME | |
| 1 | Horace H. Wood | Nellie Kuhn | |
| | S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II | NFORMANT Address | |
| 1 | Yes, na, arunknawn) (If yes give war ar dates of service) 579 – 60 – 1466 Ru | th R. Wood same as #2 | |
| F | 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) | 7) \ | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) | of dancerolos | ONSET AND DEATH |
| | 157 X DUE TO | | |
| | Conditions, if ony, which gave | | |
| | rise ta immediate cause (a), Stating the underlying cause DUE TO | | |
| | last. (c) | | |
| 1 | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY |
| CEDTICICATION | | | PERFORMED? |
| CICA | 206. ACCIDENT WAS UNDERLYING (2012) 206. DESCRIBE HOW INJURY OCCURRED. (2013) | (Enter nature of injury in Port I or Part II of item 18.) | |
| TEDT | OR CONTRIBUTING CAUSE OF DEATH | Control of the control of the control of | |
| | | CE OF INJURY (Hame, farm, 20f. (City ar tawn) (Cou | inty) (State) |
| MEDICAL | Hour a.m. While Not While foctor | ory, street, Affice bldg., etc.) | ,/ (Jiule) |
| 1 | p.m. at work at work | 11/22 10/3 12/2 21 | / St // 1 1 1 |
| | 21. I certify that (I) (this haspital) attended the deceased from_ | 1/23, 1967, to [2/25, 194 | hat (I) (we) last |
| | | deoth occurred at M, from causes and on the | |
| | 220. SIGNATURE | ATTENDING MED. STAFF | TE SIGNED |
| | M.D | DIRECTOR PHYS. 122d. ADDRESS | 1-5/67 |
| | 22c. PHYSICIAN'S 16 A KREUZbung | 200 AUDICES // CO (000 | al Do |
| - | (CINTEUZDONG | 1/872 10- 40 | |
| 1 | 3a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR (| CREMATORY . 23d. LOCATION (City or Town) | (County) (State) |
| | 100000000000000000000000000000000000000 | Toledo, Ohio | CALATURE |
| | 24. FUNERAL DIRECTOR He.S. H. Hines Company | 10.00 | GNATURE |
| 1 | 2901 luth St. N.W. Washington, D. | C. DATE DEC 27 1967 John | A XIII |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers—Pages 1 and 2 shauld be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67

Montgonally standard Bishiet of Calonda Sta Silver Sang Ima Cursh agrant & C 4014 CROSS HOSPIAN 7904-1671 STINU TO ELECTION OF THE COOK OF THE CONTRACT OF 2 18 18 CE TQ32 1878 69 NEW YORK lierus II. weil Se in plant of the property of the Secretary and the second secon

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

aurs after death.

| * * 20.1 | CEKTIFICATE | OF DEATH | | 17410 | | |
|--|----------------------------|--|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgemery | MARYLAND | Maryla | ngton b. coun | on: Residence before odmission) IY Montgromery | | |
| XK CRIX SX TX KOTT | ENGTH OF STAY IN 16 DOA | c. CITY OR TOWN (If outs | de corporote limits, write RUF ensington | 13-1 | | |
| d. NAME OF HOSPITAL OF INSTITUTION (If not in hospitol, give st Silver Spring Holy Cross Hospital | treet oddress) | d. STREET ADDRESS W | ahington St. | e. IS RESIDENCE ON A FARM? YES NO | | |
| (Type or print) | Herbert | wright | 4. DATE Mont OF LE DEATH | 19 | | |
| S. SEX 6. COLOR OR RACE 7. MARRIED WIDOWED | NEVER MARRIED 8. DIVORCED | DATE OF BIRTH OO | 9. AGE (In yeors last birthday) 97 yrs. | IF UNDER 1 YEAR IF UNDER 24 H Months Doys Hours M. | | |
| during most of working life, even if retired) INDUSTR electrician | F BUSINESS OR RY | 3 | ton, DC | 12. CITIZEN OF WHAT COUNTRUS | | |
| 13. FATHER'S NAME Herbert Wright | | 14. MOTHER'S MAIDEN NA | Me Manning | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yesynegrunknown) (If yes give wor or dotes of service) 218 | 17. IN 8 05 6066 | Ethel W. | Addre Wright same | ss item # 2-wife | | |
| 18. CAUSE OF DEATH (Enter only one couse per line for (o), (I PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | b), ond (c).) | Je C | Il Que | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if ony, which gove) (b) | 2 | 2 | · 0:0/ | (O. 24 eas | | |
| rise to immediate couse (a), stating the underlying couse last. | come as | lenge | Device. | 27000 | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES \(\sigma \) NO | | | | | | |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | E HOW INJURY OCCURRED. (E | Enter noture of injury in Po | rt I or Part II of item 18.) | | | |
| 2Dc. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 While of work | Not While foctor | E OF INJURY (Home, form, ry, street, office bldg., etc.) | 2Df. (City or town) | (County) (State | | |
| 21. I certify that (I) (this haspital) attended the deceased fram, 19 45, to, 19 2, that (I) (we) last saw the deceased alive on, and that death accurred at 2224 M, fram causes and an the date stated above. | | | | | | |
| 220. SIGNATURE 220. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED PHYS. DIRECTOR PHYS. 2 - 2 4 - 6 5 | | | | | | |
| 22 PHYSICIAN'S J.S. Rogers NAME (Type) | 4 | 79 19 RESemin | nary Rd., Silve | er Spring,Md. | | |
| PEMOVAI (Specific) | c. NAME OF CEMETERY OR CO | REMATORY . | 23d. LOCATION (City or Tov Rockville, 1 | , , , , , , | | |
| 24 SUNESA PIREMIOR eler Funeral Home-1 | 33 aprestockvill | e Pike 250. REC'D | | GISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely fitted in director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon paper, shauld be filed with the State Dept. of Health priar ta burial, crematian, or removal, and in any event, within 22. VR A15 (4) 25M 1/67

TIALA room at a contract of the second and parameters. The state of the s 111 , 115 11 Sep durates desired Situate we derlying to a court of the court of MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

| | 25 25 60 | CENTITICATE | OI DEATH | | 17411 | |
|---------------|--|---|---------------------------------|------------------------------|-----------------------|-------------|
| | PLACE OF DEATH | | 2. USUAL RESIDENCE (When | | | ssion) |
| | o. COUNTY mon 190: | MORY MARYLAND | o. STATE Marulo | b. COUN | Montagner | |
| - | h CITY OR TOWN (If outside corporate limber) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside | | | |
| | write RURAL and give nearest town) | and All Mills | Wheaton | | 15-1 | |
| - | d. NAME OF HOSPITAL OR INSTITUTION (If not in hos | 19 Mos. Mos. | d. STREET ADDRESS | - | I a IS PE | SIDENCE |
| | | spilot, give siteer oddress) | | 11.11 12 1 | ON A | FARM? |
| | 11931 Viers Mill Road | | | Mill Road | YES L | NO EX |
| 3. | NAME OF First DECEASED | Middle | Lost 4. | DATE Mont | | Year |
| | (Type or print) James | | CHNER | OF DEATH DEC | 1 | 961 |
| S. | SEX 6. COLOR OR RACE 7. MA | RRIED NEVER MARRIED B | . DATE OF BIRTH | AGE (In years lost birthdoy) | Months Doys Hour | DER 24 HRS. |
| / | TAIR WhITE WID | OWED DIVORCED | 12/27/19 | 47 yrs. | Months Doys Hour | 5 19101. |
|)0 | | 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (County & Sto | ote, or foreign country) | 12. CITIZEN OF WHAT | - |
| | ing most of working life, even if retired) | HI-FI Equipmes | Anderson 9 | ndiana | COUNTRY? | |
| 13. | FATHER'S NAME | The Cyulphen | 14. MOTHER'S MAIDEN NAME | | Wat a la | |
| | Floyd Zehner | | Trong Sandi | iter Shaffer | | |
| | WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. IN | IFORMANT | 0 | S A1 . 1 1 1 1 | |
| Ye | s,,no, or unknown), (If yes give wor pr dotes of service | l e | | Wheaton, Me | Mill Road | |
| | jes WW 11- Norea | yes Mar | garet Zehner | wheaton, 110 | | |
| 1 | 1B. CAUSE OF DEATH (Enter only one couse per I PART I. DEATH WAS CAUSED BY: | 17.17 | 1 | 0 7 | INTERVAL E | |
| | IMMEDIATE CAUSE (o) | acule myoca | Adia/ In | taxclion | MINU | 72.5 |
| | T DUE TO | | | 1870 17 2.0 | | |
| | Conditions, if ony, which gove) (b) | ar Terio scier | ·Tic Hear | 1 Disea | se 2 ye | aRS |
| | rise to immediate couse (a), Stating the underlying couse DUE TO | | | | | |
| | last. (c) | | | | | |
| ~* | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU | UTING TO DEATH BUT NOT RELATED TO TI | HE TERMINAL DISEASE CONDITI | ON GIVEN IN PART 1(o) | 19. WAS A | JTOPSY |
| CERTIFICATION | | | | | PERFOR | NO 🗆 |
| FICE | 20o. ACCIDENT WAS UNDERLYING □ | 205. DESCRIBE HOW INJURY OCCURRED. (I | Enter noture of injury in Port | Lor Port II of item 18.) | | |
| K | OR CONTRIBUTING CAUSE OF DEATH | and a section of the | sind notice of injury in torr | | | |
| MEDICAL (| (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20d. INJURY OCCURRED 20e. PLAC | E OF INJURY (Home, form; | 20f. (City or town) | (County) | (Stote) |
| E | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. | | ry, street, office bldg., etc.) | 201. (City of lowil) | (county) | (21016) |
| | | of work U of work U | | | | |
| А | 21. I certify that (I) (this haspital) | attended the deceased fram | June, 196 | 6 to vec | 18, 1967, that (I) | (we) last |
| ı | saw the deceased alive an <u>De</u> | <u>e // 1967</u> , and that | death accurred at 3 | M, fram causes | | ed abave |
| | 220, SIGNATURE | 11 = | ATTENDING MED | O. STAFF | 22b. DATE SIGNED | |
| | (Xaymond 1, 136 | enack mo M.D | . PHYS. DIRI | ECTOR L PHYS. L | 12/18/6 | 7 |
| | 22c. PHYSICIAN'S | - 0 - 1 - 1 - 1 | 22d. ADDRESS | 1 | | 7 / |
| | NAME (Type) & Aymond 1 | , WENACK MU | 14/15 Col | IE PR. U | chealon, | md. |
| 30 | . BURIAL, CREMATION, 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR C | REMATORY | 23d. LOCATION (City or Tox | wn) (County) | (Stote) |
| | REMOVAL (Specify) Deg. 20: | 1967 Baltimore N | ational. | Baltimore, 1 | Maryland | |
| 24 | FUNERAL DIRECTOR Concellina | ADDRESS | 2So. REC'D BY | | GISTRAR'S SIGNATURE() | 100 |
| 10 | varner Etark Phisor Inc | c. 8434 Georgia H | DATE DE | C 2 6 196/ | yeurs you | 1 |
| 216 | | OLLUET OPTING. | I I O A DAIL | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely filled in by the director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages shauld be filed with the State Dept. at Health priar to burial, crematian, or remaval, and in any event, within 72 hours at VR A15 (4) 20 M 1/66

1.15214 Addition to the second second second